S. HRG. 98-1020

MATERNAL AND CHILD HEALTH BLOCK GRANT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

JUNE 20, 1984

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MATERNAL AND CHILD HEALTH BLOCK GRANT

WEDNESDAY, JUNE 20, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m. in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press release announcing the hearing and background material on the maternal and child health block grant follow:]

[Press Release No. 84-146, May 29, 1984]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON THE MATERNAL AND CHILD HEALTH BLOCK GRANT

Senator Dave Durenberger, Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on the status of the Maternal and Child Health Block Grant.

The hearing will be held on Wednesday, June 20, 1984, beginning at 10:00 a.m. in room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Durenberger noted that, "the Omnibus Budget Reconciliation Act of 1981 substantially changed the numerous Federal categorical programs providing services to women and children by consolidating many of these programs into a block grant known as the Maternal and Child Health Block Grant (MCH).

"At the time the MCH Block Grant was created, considerable concern was raised about the possible loss of support for these programs and the resulting decrease in the availability of services. As a result, the General Accounting Office was asked to monitor the implementation of this block grant along with the others created at that time."

Senator Durenberger further noted that "the GAO has recently published the results of their study. The purpose of our hearing will be to provide the members of the Subcommittee the opportunity to question the GAO on their findings. In addition, we will be interested in hearing from other groups, including the Administration, on the results of their reviews of the MCH Block Grant and current state activities in this area."

THE MATERNAL AND CHILD HEALTH (MCH) BLOCK GRANT PROGRAM—BACKGROUND PAPER

Legislative History

The Maternal and Child Health (MCH) program was authorized by the Congress in 1935 under Title V of the Social Security Act. The purpose of the program was to enable each State to extend and improve services to reduce infant mortality and promote the health of mothers and infants, especially in rural areas and in areas suffering from severe economic distress. The program also provided for training and research activities to advance MCH services and provided support for crippled children's services.

The early focus of the program was on preventive health services. Well-child conferences, dental hygiene, education, prenatal counseling, public health nursing, and supervision of maternity clinics were the basic services.

The Title V MCH program remained basically unchanged until the mid-1960's, when a new program of special purpose grants for projects in low-income areas, training personnel, and research projects relating to MCH services were authorized in addition to the existing formula grants. In 1963 Congress authorized the Maternity and Infant Care (M & I) program under Title V (P.L. 88-156) to provide adequate prenatal care to lower the risk of mental retardation and infant mortality.

However, the largest, most significant changes to MCH occurred in 1981. The Title V program, though one of the oldest Federal programs for women and children, was only one of many programs providing services for those populations. At least 35 other programs existed in 1981 that provided either direct health care services or support services for health care targeted to these same groups. The Reagan administration fiscal year 82 budget proposed the consolidation of 25 categorical grant programs for health into two block grants to the States. In addition to consolidation, the proposal provided for 25% less in funding than would have been provided to the programs included in the block. The Maternal and Child Health program was slated for consolidation with 14 other health programs into a new Health Services block grant.

As finally agreed upon, the Maternal and Child Health block grant consolidated seven other Federal programs under Title V of the Social Security Act: Crippled Childrens Services, Supplemental Security Income Services for Disabled Children, Lead-Based Paint Poisoning Prevention, Genetic Diseases, Sudden Infant Death Syndrome, Hemophilia, and Adolescent Pregnancy.

Program Funding

The 1981 legislation authorized $373 million for the Maternal and Child Health block grant program. The authorized amount and an additional $105 million was appropriated for fiscal year 1983.

An additional $26 million was appropriated in fiscal year 1984. Currently under consideration by the Conferees in the Deficit Reduction Act of 1984 is a Senate amendment which provides for a permanent increase in the authorization level for the MCH program to $478 million.

The MCH block grant provides funds to States which then distribute the funds to local agencies for services. The States, which receive an amount which is proportionate to the amounts they received from the previous programs must, unlike in the time prior to the creation of the block grant, match every 4 Federal dollars with $3 of their own funds.

Responsibility for the large majority of the funds lies with the States. A primary reason for the block grant format was to allow the States maximum flexibility--so the Federal guidelines are limited, though designed to ensure that at a minimum, the MCH funds will be used for the services designated in its legislative purpose.

Table 1 displays budget information for States by actual obligations for fiscal years 1981, 1982, and 1983. It also displays estimated obligations for the MCH block grant, by State, for fiscal year 1984. While data on how States are currently spending their block grant monies is not available (other than from the sample of States surveyed by the GAO), data on fiscal year 1982 expenditures is displayed in Table 2. This Table gives some idea of the program categories that were being supported in each State by the Maternal and Child Health block grant. It is not known whether these program categories have changed since fiscal year 1982. It should be noted that Table 2 reflects only those programs supported by the block grant. Other services to children and their mothers are provided by the Preventive Health and Health Services block grant, the Medicaid program, the Social Services block grant, in addition to other broad ranging Federal programs, and by programs funded exclusively through State revenues. The Children's Defense Fund notes that for fiscal year 1985, $1.6 billion will support children's health through selected categorical children's programs. (This figure includes the MCH block grant but does not include Medicaid.)

In addition to the funds allocated to the States, there is a set-aside of funds (an amount not less than 10 percent but not more than 15 percent) that the Secretary can use to support programs of regional and national significance through grants and contracts. In 1984, approximately $13.7 million is anticipated to be available for support of new projects and the renewal of existing projects on a competitive basis. Of the $13.7 million available, approximately $3.1 million has been allocated for genetics, $300,000 for hemophilia, $1.8 million for research,

$2.3 million for training, and $6.2 million for other special projects.

Services

Under the block grant a State may use its allotment for the provision of health services and related activities, including planning, administration, education, and evaluation. The statute specifically precludes the uses of funds for:

(1) Inpatient services, other than inpatient services provided to crippled children or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment, except with a special waiver;

(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(5) providing funds for research or training to any entity other than a public or nonprofit private entity.

However, a State may use a portion of its allotment to purchase technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under Title V.

The Federal set-aside noted earlier is intended to fund (1) special projects of regional and national significance; (2) training; (3) research for Maternal and Child Health (MCH) and Crippled Children (CC); (4) genetic disease testing, counseling, and information development and dissemination; and (5) comprehensive hemophilia treatment centers. Amounts retained by the Secretary for training must be used for grants to public or nonprofit private institutions of higher learning for training personnel to provide health care and related services to mothers and children. Amounts retained for research must be used for grants to, contracts with, or jointly financed cooperative agreements with, public or nonprofit private institutions of higher learning and public or nonprofit private agencies and organizations engaged in research projects relating the MCH or CC services.

Administration

At the Federal level, the MCH block grant is administered by the Office of Maternal and Child Health, Health Resources and Services Administration, Public Health Service, Department of Health and Human Services.

State health agencies, except those which administer their Crippled Children's program through other State agencies, administer the Title V block grant. There is no provision for administration of the program by Indian tribes. All 50 State health agencies plus D.C., Puerto Rico, the Virgin Islands, American Samoa, Guam and the Northern Marianas Islands operate MCH programs.

State agencies that administer the MCH program are responsible for planning, administration, education and evaluation activities. Very few State agencies provide direct health services, rather activities under the MCH block grant program are operated by local agencies either directly or through clinics under their supervision. MCH services are provided through health agencies of any political subdivision of the State or any other public or nonprofit private health agency, institution or organization receiving funds from the State health agency to provide such services.

Reporting Requirements

States--States must meet two kinds of reporting requirements under the MCH block grant. First, there are those which a State must meet in order to receive a block grant allotment. Second, Title V specifies other requirements which a State must meet after it has received its allotment. In addition, a State must audit its block grant program expenditures every 2 years.

In order to receive an MCH block grant allotment, each State must prepare a report describing the intended use of its grant including (1) a description of those populations, areas, and localities which the State has identified as needing MCH services; (2) a statement of goals and objectives for meeting those needs; (3) information on the types of services to be provided and the categories or characteristics of individuals to be served; and (4) data the State intends to collect on program activities. A State must also transmit a statement of assurances to the Secretary of Health and Human Services (HHS) indicating, among other things, that it will provide a fair method for allocating allotted funds based on its report on intended use of expenditures; it will spend a substantial portion of its allotment to provide health services to mothers and children with special consideration given to continuing previously funded special projects; and that the State administering agency will coordinate activities between the block grant and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid as well as with other Federal grant programs.

A State must also prepare annual reports on the activities undertaken with its block grant allotment. These reports must provide information necessary to evaluate and compare the performance of different States assisted under the block grant as well as assure the proper expenditure of funds under the block grant. States must also conduct biennial audits on program expenditures.

Federal--Title V requires that, at the Federal level, the office designated to administer the program within the Department of Health and Human Services, the Office of Maternal and Child Health, must cooperate with the National Center for Health Statistics to collect, maintain, and disseminate information relating to the health status and health service needs of mothers and children. The authority also requires that the Secretary report annually to Congress on the set-aside activities funded under the block grant. In addition, the Secretary must report to Congress on MCH block grant activities no later than October 1, 1984, and include any recommendations for appropriate changes in the block grant legislation.

Program Data

One of the weaknesses of the MCH and CC programs in the past has been the inability of the States or the Federal Government to gather sufficient data on the population served or the specific services provided.

In its 1980 report, Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome, the GAO pointed out that little was known about the services provided under Title V or the population it served. While there are reporting requirements in the law, not all States report under the system, and those that do report data sometimes confuse the information with the inclusion of services provided under programs other than Title V.

1984 GAO Report

On May 7, 1984, the General Accounting Office reported to Congress on the State administration of the MCH block grant since its inception in 1982. GAO did its work in 13 States: California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont and Washington. Together these States receive 40 percent of the national MCH block grant appropriations and account for about half of the Nation's population. While these States represent a diverse cross-section, the GAO cautions that their findings cannot be projected for the entire country.

Because they emphasized the need to maintain program continuity, the States generally have continued to support activities similar to those funded under the prior categorical programs. The States, however, have used their block grant flexibility to alter program priorities and some offered services. The scope and dimensions of the changes vary.

Under the MCH block grant, the GAO found that many States assumed new responsibilities for five smaller prior categorical programs, which together account for less than 8 percent of total expenditures. Between 1981 and 1983, expenditures decreased in 7 of the 8 states offering lead-based paint poisoning prevention activities and in 8 of 12 States reporting expenditures for sudden infant death syndrome services. While States' flexibility increased in the areas of adolescent pregnancy prevention, hemophilia, and genetic disease testing and counseling, a large percentage of total expenditures for these programs continued to come directly from the Secretary's set-aside fund. Moreover, trends among States in these areas varied widely.

State executive and legislative branch officials generally seem to view the block grant approach to be more desirable than the prior categorical approach. They found the block grant increased flexibility and was less burdensome. Conversely, the GAO found that interest groups tended to view the block grant as less desirable. While interest groups and State officials had differing views, both expressed concern about the federal funding reductions that accompanied the block grant, which from their perspective tended to somewhat diminish its advantages.

Issues of Block Grant Implementation

While block grants as a financing mechanism for maternal and child health programs provide local and State officials with the opportunity to better tailor programs to meet local needs, opponents have feared that block grants would not be implemented adequately or sensitively. Three years after implementation of the block grants, Congress is now able to begin to look at how that money is being spent and how well.

Some of the questions of interest in comparing how block grant funding patterns compare to the original categorical programs include:

-- What program activities are funded and at what levels?

-- How have States handled Federal budget reductions and adjusted the amount of State funds committed to various program activities?

-- How did the States decide how to use and distribute block grant funds?

-- How did the States obtain and consider the views of local governments, service providers, advisory bodies, and interest groups?

-- What services were provided and populations served with block grant funds?

-- What has changed as a result of State and service provider funding decisions?

-- How well are States complying with block grant requirements regarding civil rights protection, matching requirements, audits?

-- How have block grants affected program organization and service delivery?

-- What financial and program management controls have been established for block grant funds?

-- What information are States obtaining for managing block grants?

-- How detailed is information maintained at the State level?

-- Will State annual reports, plans, and application submissions be accurate and comparable?

-- What steps have Federal agencies taken to ensure that State reports, plans, and applications are reliable and accurately portray States block grant activities?

The Maternal and Child Health block grant has been in place since 1982. State officials have had the opportunity both to respond to the increased flexibility provided by the block grant and to respond to the decreased levels of Federal funding that accompanied them. The hearing of the Subcommittee on Health is designed to provide Members of the Committee with a review of State activities in this area, where these activities have been successful and where the block grant might need changes.

TABLE 1

BUDGET INFORMATION FOR STATES

Agency: Health Resources and Services Administration
Program Title: Maternal and Child Health

State/Territory	FY 1981 Actual Obligation	FY 1982 Actual Obligation	FY 1983 Actual Obligation	(Amount in $000's) Estimated Obligations FY 1984
Alabama	$7,879	$6,855	$9,150	$7,353
Alaska	757	658	878	705
Arizona	3,707	3,225	4,305	3,459
Arkansas	4,752	4,133	5,516	4,433
California	20,948	18,223	24,323	19,545
Colorado	5,110	4,446	5,934	4,768
Connecticut	3,292	2,862	3,820	3,069
Delaware	1,477	1,284	1,714	1,377
District of Columbia	5,756	5,009	6,685	5,372
Florida	10,656	9,271	12,375	9,944
Georgia	10,621	9,239	5,672	9,910
Hawaii	1,582	1,375	1,836	1,475
Idaho	2,305	2,005	2,676	2,150
Illinois	14,434	12,553	16,755	13,464
Indiana	8,390	7,298	9,741	7,828
Iowa	4,886	4,250	12,332	4,558
Kansas	3,284	2,855	3,811	3,063
Kentucky	7,885	6,858	9,154	7,356
Louisiana	8,532	7,421	9,906	7,960
Maine	2,556	2,223	2,967	2,384
Maryland	8,975	7,807	10,420	8,374
Massachusetts	8,214	7,143	9,534	7,661
Michigan	12,972	11,282	15,059	12,101
Minnesota	6,679	5,812	7,757	6,234
Mississippi	6,459	5,622	7,504	6,030
Missouri	8,616	7,494	10,003	8,038
Montana	1,699	1,477	1,971	1,584
Nebraska	2,959	2,574	3,435	2,761
Nevada	895	778	1,038	834
New Hampshire	1,505	1,309	1,747	1,404
New Jersey	7,943	6,909	9,222	7,410
New Mexico	2,584	2,251	3,005	2,415
New York	26,820	23,329	31,139	25,023
North Carolina	11,416	9,929	13,252	10,649
North Dakota	1,360	1,182	1,578	1,269
Ohio	15,246	13,261	17,701	14,224
Oklahoma	4,680	4,069	5,432	4,365
Oregon	4,233	3,681	4,913	3,948

(Amount in $000's)

State/Territory	FY 1981 Actual Obligation	FY 1982 Actual Obligation	FY 1983 Actual Obligation	Estimated Obligations FY 1984
Pennsylvania..................	17,084	14,858	19,832	15,937
Rhode Island..................	1,143	993	1,325	1,065
South Carolina................	8,031	7,029	9,382	7,539
South Dakota..................	1,629	1,416	1,891	1,519
Tennessee.....................	7,772	6,760	9,023	7,251
Texas.........................	18,583	16,164	21,575	17,337
Utah..........................	4,512	3,924	5,238	4,209
Vermont.......................	1,307	1,135	1,515	1,218
Virginia......................	8,720	7,586	10,125	8,136
Washington....................	5,884	5,116	6,829	5,488
West Virginia.................	4,645	4,041	5,394	4,334
Wisconsin.....................	7,924	6,893	9,201	7,394
Wyoming.......................	913	794	1,059	851
American Samoa................	326	285	380	305
Guam..........................	507	440	587	471
N. Mariana Islands............	310	269	359	288
Puerto Rico...................	10,537	9,163	12,231	9,829
Trust Territory...............	598	519	692	556
Virgin Islands................	992	863	1,152	926
Indian Tribe Set Aside........	---	---	---	---
Undistributed, 15% Set-Aside...	93,240	57,550	55,950	59,850
Total........................	$456,772	$373,750	$478,000	$399,000

NOTE: FY 1982 was the first year of the Block Grant.

TABLE 2

PROGRAMS SUPPORTED UNDER THE MCH BLOCK GRANT, BY STATE, FY 82

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	MD	MA	MI	MN	MS	MO
Maternal & Ch. Health (Gen.)	X	X	X	X		X	X	X		X	X	X			X	X	X		X	X	X	X	X	X	X
- Maternity & Infant Care				X					X	X		X	X	X				X							X
- Children & Youth				X					X	X		X					X						X		
- Child Health Surveillance/ EPSDT										X			X	X									X		X
Intensive Newborn Care		X																							
Perinatal Programs				X							X						X								
Child Development Programs		X							X																
Men. Retardation/D.D.																				X					
Vision, Speech, Hearing		X		X																			X		
Family Planning				X			X	X	X	X			X					X		X	X		X		X
Lead Poisoning/Poison Control								X	X					X							X				
School Health									X																
Birth Defects/Genetic Services																	X						X		
WIC Supplemental Food								X																	
MCH Nutrition (other than WIC)													X												
Sudden Infant Death Syndrome																									X
Dental Health		X						X	X	X			X		X	X				X	X			X	X
Crippled Children's Services		X					X				X	X	X												X
Immunization/ Communicable Disease Control				X						X											X			X	X
Chronic Disease Control																								X	
Heath Statistics							X				X		X				X								
Ment. Health, Alc. & Drug Abuse																									
Other									X		X						X				X				

TABLE 2 (cont.)

PROGRAMS SUPPORTED UNDER THE MCH BLOCK GRANT,
BY STATE, FY 82

	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WY
Maternal & Ch. Health (Gen.)	X		X	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X	X		X
- Maternity & Infant Care	X												X			X		X		X		X	
- Children & Youth	X															X		X		X	X	X	
- Child Health Surveillance/ EPSDT													X									X	
Intensive Newborn Care																				X		X	
Perinatal Programs														X	X	X							
Child Development Programs							X									X			X	X		X	
Men. Retardation/D.D.																							
Vision, Speech, Hearing																X	X	X					
Family Planning	X		X	X	X		X	X		X	X	X		X	X	X	X					X	X
Lead Poisoning/Poison Control				X									X										
School Health												X											
Birth Defects/Genetic Services	X						X					X	X			X		X			X		
WIC Supplemental Food										X				X	X	X						X	
MCH Nutrition (other than WIC)																							
Sudden Infant Death Syndrome															X								
Dental Health	X	X		X	X		X	X		X	X	X		X		X	X	X			X	X	X
Crippled Children's Services		X		X	X		X		X			X	X	X	X	X	X	X	X	X	X		X
Immunization/ Communicable Disease Control										X	X			X	X	X			X				
Chronic Disease Control										X				X	X							X	
Heath Statistics									X						X								
Ment. Health, Alc. & Drug Abuse										X					X								
Other							X		X	X					X	X			X				X

Note: Three States, Maine, Montana, and Wisconsin, are not represented.

SOURCE: Association of State and Territorial Health Officials Foundation, Inventory of Programs and Block Grant Expenditures. April 1984.

Senator DURENBERGER. The hearing will come to order.

Let the record show that it is 10 o'clock, not 2 minutes to, but give me credit for starting on time.

The history of Federal Government involvement in maternal and child health issues goes back to the passage of title V of the Social Security Act, 1935. At that time funds were provided to the States to extend and improve preventive health services for mothers and children, particularly those living in rural areas and in poverty.

Since then, many small and often narrowly focused categorical programs have developed throughout the country. The Omnibus Reconciliation Act of 1981 consolidated eight of these maternal and child health [MCH] programs into a single consolidated Federal block grant to the States, the maternal and child health block grant.

Congress consolidated these programs to allow States to better tailor MCH services to the needs of their people.

There is some concern about the effect of the new MCH block grant on the people of this country, on State and local government, particularly with respect to the decisions that government makes about which programs to fund and what the overall effect has been on the health status of mothers and children.

Although States were given greater flexibility in the design and distribution of the program dollars, there has been evidence to suggest that expenditures for maternal and child health services at the State level may be declining.

Today we will take a look at a report released on May 7, 1984, by the General Accounting Office on the "State Administration of the Maternal and Child Health Block Grant." This report is the first look we have had at what the States are doing with the funds distributed under the MCH block grant. We have asked a variety of experts to testify with regard to the implementation of the block grant program, and we look forward to hearing all of their testimony on the subject of maternal and child health.

Let me say that I approach this issue not only from the standpoint of chairman of the Health Subcommittee of Finance but also as chairman of the Intergovernmental Relations Subcommittee of the Governmental Affairs Committee, in which I have a deep concern for the role that State and local government play in implementing national commitments in the area of health, particularly, health for those who cannot avail themselves of private sector insurance.

It is my impression that we will hear a variety of testimony today, some of which will be an incremental approach to the problem. We will get into statistical arguments here as we have when we looked at how many economically disadvantaged there are here in this country, and people will throw out constant dollars and real dollars and inflation, and they will compare 1981 and 1984 and try to draw some conclusions about the adequacy of health care for mothers and children in this country.

From my standpoint, that's the way we have been doing things in this Congress and in this society of ours for too long.

There is a report somewhere in this looseleaf I was given entitled "The Maternal and Child Health Research Grants Program—Inventory of Projects." When I go to the back of this report I find this incredibly long list of the grants that have been issued under this program prior to September 30, 1983. It looks like everything to do with pregnancy, mothering, child rearing, and whatever else you can think of has been studied. And it's been studied for $112,000 here and $84,000 there and $161,000 here. And I don't find that the infant mortality rate in the United States of America has improved one whale of a lot since all of those studies came out.

I still find in my own community, per capita we have three times the number of neonatal intensive care beds that they have in Oslo, Norway. as a country, We still focus on what happens after birth rather than the problems that occur during pregnancy.

Frankly, as far as the chairman of this subcommittee is concerned, I appreciate the fact that there has been almost a 50-year commitment by the Federal Government to the problems of maternal and child health; but I suspect also that we have enriched a lot of pediatricians and of other researchers in this country with a lot of information—including the NIH.

But in terms of a real positive impact on maternal and child health in America, I just wonder if we are moving in the right direction.

So, I will just throw out that wonderment and let the people who testify here today help me feel good about this problem. I also know that we are committing $355 billion this year to sick care in America, and a substantially smaller amount to health care. And as the Government-supported bill and the privately supported bill for sick care in America goes up, the ability of America to finance health care goes down. All of the incentives in this system are to get sick, and none of them are to prevent people from getting sick, and we are now engaging in a great debate, which the Governor of Colorado launched us into a few weeks ago, about who lives and who dies in America.

But I welcome the debate—not because I think we are at the stage where we have to decide whether neonatal intensive care is more appropriate than geriatric care, but principally because I think that having to focus on some of the issues of how much society can afford to provide for people of various ages and conditions will cause us to focus on the fact that in America we have more than enough resources to take care of everybody—more than enough. We are just wasting so much of the resources that are available to us.

It strikes me that there is no better area than the area of maternal and child health in which to demonstrate waste in this system. If the accent is on taking care of the problems after they occur rather than preventing problems from occurring, then that is the wrong kind of an accent. If the maternal and child health block grant, or any other grant commitment by this Government to other levels of government and to people in our society, is putting the accents in the wrong area, then I would like to know about it. And perhaps with your help over the next 6 to 8 months we can redesign title V of the Social Security Act to give it some real meaning.

I was pleased to join my colleague from Texas, Lloyd Bentsen, here earlier this year in a commitment that we passed through this committee under the Deficit Reduction Act—and Lord knows what is going to happen to it there—which would permanently increase the authorization level for the MCH block grant from $373 million to $478 million. But I want the record to show, and for all the people who are here, that I don't measure the adequacy of our commitment to mothers and children in America by $478 million any more than I measure it by the $373 million. It is largely how we spend that money as a society—how we invest it—that concerns me. And if we at the national level can restate our commitment to mothers and children in this country by revising the title V commitment in the Social Security Act, then I would invite all of the people who are here today to express a willingness to come back over the next several months and help us to redesign that particular commitment.

Some of you know we are already committed to doing that with regard to title XIX, and perhaps some of the other titles of Social Security. We have had a series of hearings on the economically disadvantaged in America, and let the record show I am not wedded to the medicaid program when I know that so many people are falling through the so-called cracks in our society because we have decided to take the Social Security Act and divide it up into titles through which a lot of people can fall.

So, with that set of general observations, let me welcome the witnesses, the first of whom will be Mr. Richard Fogel, who is Director of the Human Resources Division of the General Accounting Office, Washington, DC, who will enlighten us on the GAO report I referred to earlier.

STATEMENT OF RICHARD FOGEL, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY BILL GADSBY, GENE DODARO, AND BILL MILLETARY

Mr. Fogel. Thank you, Mr. Chairman.

I would like to introduce the staff with me today and explain their role. As you may know, GAO has undertaken a comprehensive review of eight of the block grants that were passed in 1981. Bill Gadsby and Gene Dodaro are the project directors of that total effort, and Bill Milletary was the project leader on the MCH block grant.

We are pleased to be here today to discuss our MCH report, which provided a picture of how the MCH block grant was implemented in 13 States. These States included a diverse cross-section of the country and accounted for about 40 percent of the national MCH block grant appropriation, and about 48 percent of the Nation's population.

Although Federal appropriations decreased by about 18 percent as States implemented the block grant, most were able to maintain total funding for maternal and child health programs. Over the 1981 to 1983 period, total expenditures increased in 10 States while declining in only 3. The increases ranged from 1 percent in New York to 42 percent in Vermont. However, after adjusting for inflation, only 5 of the 13 States experienced an increase in constant dollars.

The availability of prior categorical funds during States first year of block grant implementation was a key reason why maternal and child health expenditures increased. During the States first block grant year, categorical funds comprised at least 31 percent of combined categorical and block grant funds in 10 of the 13 States. However, as categorical outlays diminished in 1983, State funds began shouldering a greater portion of total MCH expenditures.

Ten of the thirteen States increased the expenditures of State funds between 1981 and 1983, ranging from about 1 percent in New York to 85 percent in Texas. In many of these States the growth in State funds was the primary factor contributing to overall funding increases for MCH programs.

The MCH block grant received another $105 million in March 1983 when Congress passed the Emergency Jobs Appropriations Act. This increased the original 1983 Federal allocations in 13 States by about 33 percent and restored Federal support to 1981 levels. These funds were received late in the States fiscal year 1983 and were to be spent mainly in fiscal year 1984, primarily for maternal and child health and crippled children's services with emphasis on economically disadvantaged individuals.

States generally continued to support activities similar to those funded under the categorical programs as they emphasized the need to maintain program continuity. However, States altered program priorities and some services offered.

The States had considerable involvement in the crippled children's and maternal and child health categorical programs, which accounted for 92 percent of total expenditures in 1981. Expenditures for these two program areas increased in 1983, although their share of total expenditures remained the same. The types of services offered remained essentially unchanged for these programs, although the States refocused aspects of each program area.

Many States also assumed new responsibilities for five smaller prior categorical programs. Between 1981 and 1983, expenditures decreased in 7 of the 8 States offering lead-based paint poisoning prevention activities, and in 8 of the 12 States reporting expenditures for sudden infant death syndrome services. While States flexibility increased in the areas of adolescent pregnancy prevention, hemophilia treatment centers, and genetic disease testing and counseling, a large percentage of total expenditures for these areas were the result of continued direct Federal funding, including the Secretary's set-aside fund.

While the 13 States were adjusting program priorities, the 44 service providers we visited experienced a wide variety of changes. Some reported stable or increased funding and expansion of program operations, while others experienced funding declines. Where funding had declined, changes ranged from reduced staffing and services to sustained operations by increasing fees and other funding sources, improving efficiency, and using more volunteers. Certain changes were attributed to the block grant, but usually providers pointed to an array of factors influencing their operations, particularly escalating costs, changes in other sources of funds, prevailing economic conditions, and changing client needs.

The financial and administrative responsibility the Federal Government and States have shared for maternal and child health programs provided an established framework for States to assume their expanded block grant management role. As a result, States generally assigned block grant responsibilities to offices which administered the categorical programs and made only minimal changes to their organization and the service provider network. Also, block grant program management activities were often integrated with ongoing State efforts.

While we could not quantify cost savings associated with using the block grant approach, there were indications of administrative simplification. According to State officials, the block grant influenced about half the States to change or standardize their administrative requirements, improve planning and budgeting, make better use of State personnel, and to reduce the time and effort involved in reporting to the Federal Government.

States obtained advice for making decisions on how to use block grant funds from several sources. In addition to preparing required reports on the planned and actual use of funds, all 13 States held public hearings, and 10 used one or more advisory groups.

State officials generally believed that levels of public participation were greater under the block grant than under the categorical programs. Also, program officials noted that the Governors and legislatures had become more involved in six States.

The major area of interest groups 'satisfaction with the States citizen-input process was with the accessibility of State officials for consultation. The major areas of dissatisfaction related to the availability of information prior to hearings and the time of hearings relative to the States decisionmaking process. However, interest groups that actively participated in the States decisionmaking processes tended to be more satisfied with how the block grant process was working at the State level.

State officials liked the block grant's increased flexibility, and they found it to be less burdensome. Generally, they viewed the block grant to be more desirable than the categorical approach; however, most interest groups perceived the block grant approach to be less desirable.

While interest groups and State officials had differing views, both expressed concern about the Federal funding reductions which, from their perspective, tended to diminish its advantages as a simplified administrative mechanism.

We would be pleased to respond to any questions you may have.

Senator DURENBERGER. Thank you very much.

Let me ask you to give us a little bit more detail on the reaction to the presumption that was articulated when the block was put together, and that is that the relief from mandates and the so-called administrative burden would somehow offset the reduced financial commitment to the block grant. And I ask for some specificity, perhaps by way of example.

Mr. FOGEL. Sure.

One thing we found is that the States did pick up positively on the legislation that enabled them to decide how they wanted to spend some of the money.

I would like to let Mr. Dodaro go into some detail on that in terms of some shifts in the program areas, both within the block grant and also among the former categorical programs.

There is one thing I want to emphasize, though, before we get into some detail:

We noticed a trend in all of the health blocks, that when States started making funding decisions they tended to support those health programs where they had historically had more involvement, and they had a tendency to increase their own State funding in those programs where they had historically had a long-term commitment.

So in areas such as the lead-based paint poisioning program, or sudden infant death syndrome, there was a tendency to reduce support for those while supporting more efforts in the MCH and crippled children's areas.

Mr. Dodaro can get into some more detail on that.

Mr. **Dodaro**. Senator, the primary method that States used to offset declining Federal support came in really two dimensions. One was a built-in mechanism in the Federal categorical grant-in-aid process, whereby categorical funds awarded during 1981 extended into 1982 and overlapped with State funding for block grant implementation. This provided additional time and resources for the States to adjust to the reduced levels, and it also enabled them to carry over block grant moneys into future years as opposed to immediately assuming all of the demands placed upon them.

Additionally, many of the States increased their own funds for these particular programs over the period.

Mr. **Fogel**. I could give you some examples for that specifically. For example, between 1981 and 1983 total expenditures for crippled children increased 23 percent; maternal and child health—1 percent; genetics, 15 percent; adolescent pregnancy, 16 percent; hemophilia, 3 percent. But the sudden infant death syndrome decreased 12 percent; the lead-based paint program prevention activities decreased 19 percent; and support for disabled children receiving supplement security income decreased about 10 percent. And that trend is not just evident in this block, it was evident in the preventive health block and in the alcohol-drug abuse prevention block grant too The States generally put more of their own money in to make up for the gap in the programs that they had been operating for a number of years.

Senator **Durenberger**. Well, does that tell us that we were wrong in the national mandate on sudden infant death and lead-paint poisoning, and so forth, or does it just tell us that those problems have been resolved and those States are going back to traditional maternal and child health and crippled children services?

Mr. **Fogel**. I can't give you a direct yes or no answer. Let me say this: We are very pleased with the analysis that showed that the decisionmaking processes that the States went through was a very good process in terms of hearings, in terms of getting input from interest groups, from affected parties.

There were some problems, as we said, in this block. Some of the interest groups felt that if they had had a little more advanced knowledge on when the States were going to make their decisions, they might have had a little more impact.

But it is interesting that all of the States—for example, in this block—did more than was required by the statute in terms of getting input. The statute had only required that they provide an intended-use report. But 10 States held executive hearings, 11 States held legislative hearings, and 10 States went to advisory groups.

So, the only thing we can say in answer is that the States appeared to get a lot of input into the decisions they made on how they wanted to spend the money. That doesn't necessarily mean, though, that the Congress was wrong in saying there are some national problems. And that's why we tend to support the set-aside provisions as a way in a block grant to get some national emphasis without going all the way back to a categorical approach on some of these problems.

Senator **Durenberger**. I want to go back and get a response to the efficiency part of my questions, which dealt with mandates and the accountability factors like the administrative costs, and so forth. Is there a way to measure that?

Mr. **Fogel**. Well, I'll let Mr. Gadsby give us some detail on that. The indications we got from the State officials is that they could deal more efficiently with some things. Certainly, from a standpoint of planning and allocating total health dollars in a State, the block grant approach enabled them to consider the whole much better than the categorical approach did.

However, it was very difficult for us—and I can assure you that the Comptroller General pushed us pretty hard—to try to come up with specific administrative cost savings and measurements.

Senator **Durenberger**. Well, the administration doesn't have any problem doing that. I mean, there is $15 billion here, and $15 billion there, and we are saving money all over the place.

Did they pull those sorts of things out of the air? Maybe you can tell us how difficult it is.

Mr. **Fogel**. Yes. We couldn't find any evidence based on what happened in the 13 States to support those numbers. I'll let Mr. Gadsby get into some detail.

Mr. **Gadsby**. As far as administrative simplification is concerned, what we got from State officials was two reactions, basically. They saw in the block grant added responsibilities, in the context of the management activities they took over. The Federal Government had been doing a lot of the management before, and now the States were involved with establishing program requirements, providing technical assistance, monitoring, auditing funds, collecting data, and so forth. The States viewed that as added responsibility, more administration, more administrative costs.

On the flip side, we find that a number of the States were also reporting that there were administrative simplifications. Six of the thirteen States that we looked at were saying that they were spending less time and effort in reporting to the Federal Government. Seven said they were able to standardize a lot of administrative requirements across block grants, and that simplified things. Also, eight said they were able to improve their planning and budgeting activities, as Mr. Fogel alluded to; and six States also said they were able to make better use of personnel.

So there are really two sides to it.

When it came to actually determining whether there were specific administrative cost savings, we were not able to do that. There were two methodological problems involved as far as coming up with a percentage: The first one related to the fact that there were no common definitions of what constituted "administrative costs"; and the second one related to the fact that there was no comprehensive baseline data against which to make a comparative analysis with the past.

In terms of the definitions, what we found was that only six States had written definitions of what they considered "administrative costs" to be. Three were nice enough to provide unwritten definitions as we were doing our work, and there were 4 of the 13 that had none at all. The definitions varied considerably in what they considered to be "administration."

The States also used varying procedures to compute administrative costs, so there really wasn't much comparability in that area either.

In terms of baseline data, we found that only 4 of the 13 States had any baseline data on their costs of administering the program when it was a categorical grant; so we really couldn't make that comparison from the block grant years back to the categorical years.

We asked States officials what their perceptions were of block grant administration, and basically they said what I alluded to earlier, that it was a mixture of added responsibilities combined with simplification.

However, overall, the elected officials—Governors and State legislators—and the State program people favored the block grant approach to the categoricals.

Senator **Durenberger**. Well, I don't doubt that, and we are going to have some of them come in here and tell us why that is really terrific.

You don't have a chapter heading here on the intergovernmental aspects of it. Now I've got my intergovernmental hat on and two of the deep concerns about the whole blocking process are that "You just give the State legislators something to do, and by gosh, they'll do it, and we'll never see the money down here at the county or city level where we have to deal with these problems, particularly for the economically disadvantaged. Especially if you give it to those rural-dominated or suburban-rural-dominated legislatures," or, vice versa, "the city-dominated legislatures."

And when we started this, the States were so-called all going broke. Now they are supposed to be rolling in cash. But the reality is that they are going to have to give that cash back, because they taxed without anticipating an economic recovery.

My own State, I guess, is an example of where they met the highest needs—for example, highways and education. They did not meet these kinds of needs. They are giving back several billions of dollars in surplus in my State. While at the local level, if one of my county commissioners were to be in here today I would suspect that they would, particularly in the rural parts of the State, reflect the frustration that maybe this process isn't working as well as it ought to.

Would you comment on that?

Mr. **Fogel**. Sure.

One of the things we found from the service providers we talked to at the local level was that there were some frustrations; although—and maybe Mr. Milletary wants to add some more to this—it was difficult at that level for us to separate out the effect that a block grant reduction had from something else that was going on. In other words, a service provider knows that his or her organization got *x* amount of dollars and had certain requirements last year and is only getting so much this year. They tended to view it in the total context of dollars, not whether it was because of a block grant dollar or a specific State program.

Mr. MILLETARY. Senator, as we pointed out in our report, we visited 44 service providers, recognizing that there was no way that we could do anything much more comprehensive because of the time that would have been involved. Essentailly, we wanted to obtain some examples of the block grant implementation at the local level.

Basically, we found that there were a variety of change that came about at the service provider level, and a lot of those changes were directly linked to funding. The providers that were able to maintain or increase their funding levels were able to maintain their services or increase operations.

Senator DURENBERGER. From what source? I mean, there is a reference in Dick's statement to a presumption that there are some local public resources; there are also the user fees, and some cost-sharing mechanisms of some kind. Would you elaborate on that a little bit?

Mr. MILLETARY. Well, the sources of funding increases were mixed. And again, they don't relate it, as Mr. Fogel pointed out, to the block grant. I mean, they look at the total pot of funds, and many times it was very difficult for them to relate it to the block grant. Some of the service providers weren't even aware they were getting block grant money or, if they were, they didn't know how much.

When we visited service providers to find out, "What impact did the block grant have?" Many really didn't know. They look at their total picture. That is, if they had so much money to operate with last year from different sources; and the funding increased possibly due to the imposing of fees or getting money from private sources, then they were able to maintain services or possibly increase services.

But one of the things I wanted to mention that we found out at the service provider level, even when there were cutbacks, they wanted to maintain their direct medical care services. And when they did have to cut back, most of them tried to cut back in the indirect services like travel and transportation and public education. They were concerned to the extent that they could of maintaining those direct medical services.

Mr. FOGEL. One other thing I would like to say about the State legislative process: We are going to issue—in addition to reports on the individual blocks—some cross-cutting reports later this summer that deal with the extent of State administration trends across all the blocks and how the public participation involvement took place.

But I think it would be safe to say that in the first several years of the block one of those initial concerns that people had about some of the parochialism that might affect State legislative decisions hasn't been evident in the decisions that were made through 1983.

Now, as the States get into the next couple of years, we think the funding decisions are going to be more difficult because they are not going to have the categorical carryover. They are going to be faced with some other problems, they are going to have to make some tougher financial decisions, and some of these parochialisms or competing interests may then be more evident than they were in the first couple of years.

Senator **DURENBERGER**. Does your report have a bottom line recommendation to us, or not?

Mr. **FOGEL**. No. The objective was to basically report on what is happening. I think we do have some general observations, though, that really tie into two areas: the fiscal dimension and the governmental process perspective.

For a number of years, GAO has favored simplification of the governmental process, and we believed that the block grant approach is a step in that direction. There is no doubt that States have assumed their management activities. The citizen input process is good, and we would recommend that the provisions in the statutes to stay pretty similar on that.

I think one area where we have some concern—and I know it is an area you have been greatly involved in—is the audit approach. How do we share accountability? That is still a problem.

We are really in a transition phase, in terms of Federal and State responsibilities. We very strongly support the single audit approach. That is going to help us; that's not going to solve the total problem, though. We still have to let the States and the local governments understand that they have to also assure accountability through good program management and that they can't do it all through the single audit. But we believe the single audit is a step in the right direction.

The fiscal area is where the most concern is going to come in the next several years. The first several years of block grant implementation were characterized by a unique set of circumstances which promoted relatively stable funding patterns.

The health and community services block grants all had categorical funding, which extended into block grant implementation. So the States were able to carry over, for example, 1982 and 1983 block grant moneys to 1984.

And second, many States increased their own funding between 1981 and 1983.

Many States took advantage of increased Federal funding for the low-income home energy block grant to offset funding reductions in social service programs by transferring funds from one block to another.

And finally, the Congress in 1983 restored a lot of the cuts through the emergency jobs bill. So our bottom line is, as you said in your opening statement, that we anticipate probably more pressure in the next several years from a fiscal standpoint. As some of this money dries up and as States are faced with more tough financial decisions, various groups may be back to the Congress asking for more funds, or that the funds be targeted differently.

But overall, given the objectives of the block grant legislation, from what we are seeing we conclude that it is being carried out effectively at the State level.

[The prepared statement of Richard L. Fogel follows:]

STATEMENT OF RICHARD L. FOGEL, DIRECTOR, HUMAN RESOURCES DIVISION

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our report on the Maternal and Child Health (MCH) Services block grant. Our report was issued on May 7, 1984, and provides a comprehensive picture of MCH block grant implementation in 13 states. These states include a diverse cross section of the country and account for about 40 percent of the national MCH block grant appropriations and about 48 percent of the nation's population.

TOTAL EXPENDITURES INCREASE IN MOST STATES

Although federal appropriations decreased by about 18 percent as states implemented the block grant, most were able to maintain total funding for maternal and child health programs. Over the 1981-83 period, total expenditures increased in 10 states while declining in only three. The increases ranged from 1 percent in New York to 42 percent in Vermont. However, after adjusting for inflation, only 5 of the 13 experienced an increase in constant dollars.

The availability of prior catergorical funds during states' first year of block grant implementation was a key reason why maternal and child health expenditures increased. During states' first block grant year, categorical funds comprised at least 31 percent of combined categorical and block grant funds spent in 10 of the 13 states. However, as categorical outlays diminished in 1983, state funds began shouldering a greater portion of total MCH expenditures.

Ten of the 13 states increased the expenditures of state funds between 1981 and 1983 ranging from about 1 percent in New York to 85 percent in Texas. In many of these states, the growth in state funds was the primary factor contributing to overall funding increases for MCH programs.

The MCH block grant received another $105 million in March 1983, when the Congress passed the Emergency Jobs Appropriations Act. This increased the original 1983 federal allocations in the 13 states by about 33 percent and restored federal support to 1981 levels. These funds were received late in the states' fiscal year 1983 and were to be spent mainly in fiscal year 1984, primarily for maternal and child health and crippled children's services with emphasis on economically disadvantaged individuals.

STATES MOVING TO PUT THEIR IMPRINT ON MCH SERVICES

States generally continued to support activities similar to those funded under the categorical programs as they emphasized the need to maintain program continuity. However, states altered program priorities and some services offered.

The states had considerable involvement in the crippled children's and maternal and child health categorical programs, which accounted for 92 percent of total expenditures in 1981. Expenditures for these two program areas increased in 1983 although their share of total expenditures remained the same. The types of services offered remained essentially unchanged for these programs, although states refocused aspects of each program area. For example, the maternal and child health services' decreases were primarily in the program of special projects, which states were previously required to provide. Twelve of 13 states reduced or eliminated support for these projects in part because they believed that similar services were available under broader state programs.

Many states also assumed new responsibilities for five smaller prior categorical programs. Between 1981 and 1983, expenditures decreased in 7 of the 8 states offering lead-based paint poisoning prevention activities and in 8 of the 12 states reporting expenditures for sudden infant death syndrome services. While states' flexibility increased in the areas of adolescent pregnancy prevention, hemophilia treatment centers, and genetic disease testing and counseling, a large percentage of total expenditures for these areas were the result of continued direct federal funding, including the Secretary's set-aside fund.

While the 13 states were adjusting program priorities, the 44 service providers we visited experienced a wide variety of changes. Some reported stable or increased funding and expansion of program operations, while others experienced funding declines. Where funding had declined, changes ranged from reduced staffing and services to sustained operations by increasing fees and other funding sources, improving efficiency and using more volunteers. Certain changes were attributed to the block grant, but usually providers pointed to an array of factors influencing their operations, particularly escalating costs, changes in other sources of funds, prevailing economic conditions, and changing client needs.

STATES INVOLVED IN MANAGING PROGRAMS SUPPORTED WITH BLOCK GRANT FUNDS

The financial and administrative responsibility the federal government and states have shared for maternal and child health programs provided an established framework for states to assume their expanded block grant management role. As a result, states generally assigned block grant responsibilities to offices which administered the categorical programs and made only minimal changes to their organization and the service provider network. Also, block grant program management activities were often integrated with ongoing state efforts.

While we could not quantify cost savings associated with using the block grant approach, there were indications of administrative simplification. According to state officials, the block grant influenced about half the states to change or standardize their administrative requirements, improve planning and budgeting, make better use of state personnel, and to reduce the time and effort involved in reporting to the federal government.

INCREASED PUBLIC PARTICIPATION AND INVOLVEMENT OF STATE ELECTED OFFICIALS

States obtained advice for making decisions on how to use block grant funds from several sources. In addition to preparing required reports on the planned and actual use of funds, all 13 states held public hearings and 10 used one or more advisory groups.

State officials generally believed that levels of public participation were greater under the block grant than under the categorical programs. Also, program officials noted that governors and legislatures had become more involved in six states.

The major area of interest groups' satisfaction with the states' citizen input process was with the accessibility of state officials for consultation. The major areas of dissatisfaction related to the availability of information prior to hearings and the timing of hearings relative to states' decision-making process. However, interest groups that actively participated in the state's processes tended to be more satisfied.

OVERALL PERCEPTIONS OF BLOCK GRANTS DIFFER

State officials liked the block grant's increased flexibility and found it to be less burdensome. Generally, they viewed the block grant to be more desirable than the categorical approach. However, most interest groups perceived the block grant approach to be less desirable.

While interest groups and state officials had differing views, both expressed concern about the federal funding reductions which from their perspective tended to diminish its advantages.

We would be pleased to respond to any questions.

Senator **Durenberger**. All right.

Thank you all very much. I appreciate your analysis and your testimony.

Next we will have Dr. Robert Graham of the Public Health Service, and Dr. Vince Hutchins, Director of the Division of Maternal and Child Health Department of the Department of Health and Human Services.

Gentlemen, we welcome you. I suspect from my notes that you are going to endorse what we have heard from GAO about the direction we are going. Hopefully you will add some comments or perhaps expand on the comments in your written statement, Dr. Graham, relative to the SPRANS program.

I didn't mean to depreciate in my opening comments this book called "Inventory of Projects," but perhaps you can enlighten everybody in this room as to the value—other than that it feels good to pass out grants to people—the value of some of those research and other related projects as well.

Thank you very much for being here.

STATEMENT OF ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. VINCE HUTCHINS, DIRECTOR, DIVISION OF MATERNAL AND CHILD HEALTH, BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. **Graham**. Thank you, Mr. Chairman. Dr. Hutchins and I appreciate having the opportunity to appear before you this morning.

Since the prepared statement will go into the record, rather than taking a lot of time reading or summarizing that and given the set of interests that you have already defined this morning, I think I would simply say that we have found the GAO report to be a helpful and basically supportive one.

We feel from our experience that the block grant philosophy is being carried out effectively by the States, and we feel that the intent of the Congress in making that change has been realized.

I think, with that summary, I would prefer to spend the time that we have available this morning in trying to respond to specific questions and concerns that you may have.

Senator **Durenberger**. Well, you heard several of my concerns expressed in the form of questions to GAO, which dealt with the actual relief experienced by State governments and by providers, in being freed of the categorical mandates. And the responses that I got back were not necessarily results-oriented in terms of more people being provided with a greater amount of service; they were largely in the category of "We got more good feelings from governors and from State legislatures, and we had more public hearings, and people couldn't tell us exactly whether we did save the 25 percent or the 20 percent" or whatever it was, "but they sort of had the feeling that maybe this was a better way to go."

Perhaps in your capacity you could relate your endorsement of the block grant mechanism to the improvement in the quality of the delivery systems in the maternal and child health and related areas.

Dr. **Graham**. Let me try to relate that at least in part to some of the information that we have. Let me start on a more philosophic plane and then deal more with some of the specifics.

I think as we look at whatever our agenda is for the health care system in the United States, and making the necessary improvements, addressing areas where there may be problems, we have a fundamental issue before us, which is the balance of responsibilities which shall be carried out by the various public sectors—Federal, State, local. I think in that context, the changes that have gone on in the last several years show clearly a desire on the part of the administration to establish a different degree of partnership between the Federal State, and local levels for some of these responsibilities. That degree of change I think is very much reflected in this block grant program; although I am sure you are well aware that the MCH program, because it was formula-based even prior to the block, may have been some 5 or 6 years ahead of some of the other blocks because there was less of a categorical nature to it even as we went into the block.

Responding to some of the issues that you raised in your opening comments, I don't feel that we have a magic solution to a number of the questions that have been raised about equity and access to services in the United States. It is a far broader issue than simply the MCH programs or even the programs which pend before this committee and your various committee assignments.

I do feel, based upon my experience working in the health field policy sector and some passing experience in the delivery sector, that if we are to have an efficient and an effective system it is more likely to be a system where decisions are locally based rather than centrally based, and that we do have to find a workable and effective balance between public responsibility, at whatever levels, and the accountability, to make sure that those individuals who need services and who deserve services get them.

What I think we see playing out in the block grant approach is a step which is logical to a philosophy which says that there should be a different degree of partnership between the Federal and the State levels. So, as I said, that is a philosophic response to part of your question.

In the more specific response, how do we measure if this is working, how do we know, was it a good idea or a bad idea, what's the bottom line? We deal with a set of vital statistics and health statistics which have both a degree of heterogeneity to them and a degree of complexity which gives timelags; so I think it is very difficult for anyone who will appear before you today, or really within the next year, to say unequivocally "things are going very well" or "things are going terribly," because the data lag in the vital statistics which are available to us do not allow us to make categorical statements about health status, particularly in the most sensitive of measures, around infant mortality, much past 1981.

Concurrently, we do not have in the United States a mandatory, uniform health care statistics data system. It is difficult for us—prior to the block grant or after the time of the block grant—to say, "Here is the health status of Colorado." We can compare it to the health status of California and Minnesota, and we can say that on the "following 15 parameters, Colorado is better off, and in the following 7 they are worse off." That has never been something which has been required or has been effected.

The data that we do have that is collected by the National Center for Health Statistics, that looks at health status for the U.S. population as a whole, that looks at health status for subpopulations, whether by race or by age, to the time period where aggregate data is available still indicates that the health status in the United States is improving and that it is improving on different slopes and at different rates, depending upon which particular variable you are looking at; but by and large, based on the most recent comprehensive data, we are healthier than we were at the last measure.

The problem, as I said before, is to give you a comprehensive report based upon 3 fiscal years of block grant data or block grant experience in terms of the health status of the population, which this particular block is supposed to address, that in real time would be the end of fiscal year 1983 or hopefully half way through 1984. We don't have that data.

I think we are as concerned about those issues and those trends as anyone else; but, based upon the best data that is available to everyone, health status is improving. There is no indication that the curves have turned around.

Senator **Durenberger**. Let me go back to the philosophy, then, of the so-called partnership. I recall your characterization of the block as a "different" and by implication "improved degree of partnership."

Explain to me your view of the role of the Federal partner. What is the purpose of having you, Dr. Hutchins, and a variety of other people, and me, having this hearing today here in Washington, DC? I mean, why don't we just let the States run a variety of these programs? What is the value of the Federal partner?

Dr. **Graham**. I suspect if you ask any individual or set of individuals in public service what the level of partnership is, you would probably get as many answers as you had people. As long as the Federal sector continues to pay somewhere in the neighborhood of 40 cents on every health care dollar in the United States, there is no way that the Federal Government is not going to be a major partner in decisions related to the health care system and the issues that are raised.

I believe the philosophy of partnership that is reflected in the Block Grant Program and the proposal that the President made to the Congress in congressional action in 1981 and 1982 is that there should be a greater degree of non-Federal participation in the public sector, particularly at the State level, since the Constitution was based upon a concept of Federalism, and that that participation should relate not only to decisionmaking and priorities but should relate to resource allocation and resource generation. I think that's what we see playing out—it is a different philosophy and a different pattern of resource decisionmaking than was present, say 10 years ago. And I think that reflects a shift on the part of the Congress, and I think it reflects a shift on the part of the administration.

But the Federal Government is not going to go away—not at 40 cents on every dollar of the United States health care bill. It is simply, as I see it, that the Federal Government is reaching out and trying to assure that the other levels of the public sector are more involved, perhaps, than they have been before. In some cases that is going to be a willing involvement, and in some cases I think it may be an unwilling involvement, because some of the decisions which will be called for will be very uncomfortable, and it's nice to have some other group of people to put some blame on.

But, to come back again, I do believe that as we find ways to improve health status in our health care system, many of those ways that we will find to improve it will involve more local decisionmaking rather than more central decisionmaking.

Senator DURENBERGER. So, you certainly are not a devilutionist, in that you believe that this measly little $378 million—or whatever—would be better spent if we just turned this whole program over to the States.

As I understand your testimony, you are saying that, even if we don't look at it from the standpoint of a national responsibility to children in America, that we ought to look at it in terms of a national responsibility to more wisely use the dollars that we commit to the health care system since we, according to your testimony, contribute approximately 40 percent of it, and if there is a wiser and more effective way to spend those dollars, that ought to be our interest.

Now, my concern, of course, is how do we do that. In the old days we did it with mandates. We knew what they ought to do in some parish in Louisiana to make the return on our investment dollar more efficient; so we told them. Now I understand we are moving away from that sort of thing.

But then, I still have the problem that I learned about during the recess period in April when I saw an awful lot of public television because I was flat on my back. There was a 1-hour program that I think focused on Louisiana, and it was about the Health Care Programs of side-by-side parishes, and the bottom line, of course, was that a $4000-a-year investment in an older mother, the pregnant mother, was a much more efficient utilization of public dollars than the $4000-a-day to neonatal intensive care beds for unnecessary or potentially unnecessary premature births of handicapped children.

Now, if I continue to see that going on out there in America I have two choices: Either I can pump a lot more dollars into the system, or I can say everybody ought to do it the way that one good parish in Louisiana did. And then I can take that example and a hundred other examples out there and say "I like what I see here," and "I like what I see there."

I've still got to get you to answer some questions about this big long inventory and what in the world ever happens to all of that great information.

But what about that part of my role? Do I just answer that with dollars? Do I just up the block from 358 to 478? Or do I get back into the mandate business?

Dr. **Graham**. I guess the first thing I have to say is that I haven't been in Washington long enough to regard $378 million as "measly."

Senator **Durenberger**. It will get to you after a while.

Dr. **Graham**. I haven't dealt with this committee enough. I mean, I like the scope. [Laughter.]

It seems to me, though, that exactly the example you have chosen is an example which is central to the philosophy of the block grant, to a greater degree of Federalism, shared responsibility between the Federal Government and the other public sectors. That is, Louisiana may make a set of choices about its distribution of resources which meets its needs, which meets its priorities, based upon what its major problems are. That is a choice however that might not be made by me. And were you to say, "It works well in a parish in Louisiana, so those are the priorities that I want followed in Bangor, Maine," you might have a lot of people in Bangor very irritated, because the environment, the problems, the priorities may be very different there.

So I think we are both party to a very difficult set of learning exercises, as to exactly what the balance is in terms of responsibility, control and authority, and investment.

We have gone through a period of our national experience where we have had relatively more centralization of authority, responsibility and investment. That period has been marked by some positive changes in health status in pretty much any area you want to look at; yet, the gaps that concern everyone so much are there, and they continue to exist.

I think what we are trying to find now is a way to keep the general trendline for improvement of health status that we have seen over the last 20 years continuing in a positive downward trend, but at the same time——

Senator **Durenberger**. The frustration is, I heard GAO say that where pennies get pinched—I'll get back to an amount you can understand—where pennies get pinched, the problem is that direct services get the available pennies and prevention does not.

Now, if you tell me my responsibility is to shepherd in an efficient way our 40 percent of the health care dollars, I am going to say I'd rather put it in prevention, And what I will end up doing is adding to the pot so you can do both.

But if I say, "Well—I see what they did in that parish in Louisiana, and I see how some prevention activity took the infant mortality rate in South Dakota from 43rd in the country to 2 or 3—but, you know, if Bangor, Maine wants to be 43rd, I don't care"; you can't ask me to do that.

Can I ask one of you to respond to this? I mean, it must be fun to be in a foundation, just sitting there parceling out these dollars. Does one of you want to explain the efficiency of all of this?

Dr. **Graham**. Let me make sure I understood the question, because in your opening statement it seemed you were suggesting that people at NIH were enjoying inappropriate delight in passing out money.

[Laughter.]

Senator **Durenberger**. Well, I'll strike all of the implications out of my statement. You know, HCFA has one of these books, too, but it is about three times that thick, and much of it is mandated around this table— go study this, and go study that, and so forth. This one seems to have the luxury of some experts deciding that parent-infant support through lay health visitors is worth x number of dollars to study, and intrapartum intensive care, and outcome of the infant, and modification of attitudes toward the handicapped, and a combined developmental screen, and a study of a leg-walker for a limb-handicapped child, and epidemiology of retardation in a rural county. All of these things need to have some money spent on them.

Tell me how all this stuff gets pulled together for the benefit of society.

Dr. **GRAHAM**. I think since Dr. Hutchins has dealt most directly with that program for a number of years, I would like to give him the opportunity to convince you that it is a fulfilling task.

Senator **DURENBERGER**. Well, I'm sure it is for those involved. I want to know what it is doing for society.

Dr. **GRAHAM**. I think there are some answers to that.

Dr. **HUTCHINS**. Part of the responsibility of funding those projects is disseminating the information so that it is utilized. That publication you have represents 20 years of projects, so there are a lot of them in there.

One could take some examples. Some of the nutrition studies that were supported in the early 1970s looked at what is the appropriate nutrition for pregnant women, and one of those studies—it was at the National Academy of Science—changed obstetrical practice in the United States because of the findings, which said that weight gained did not have to be limited to 20 pounds, as previously asserted and salt did not have to be restricted in certain ways. But the findings coming out by themselves would probably not have done it. And so, the States using that information, which is a form of the Federal-State partnership, I think, had a series of meetings around the country promulgating the findings of that study to not only public providers who were seeing pregnant women but, also, calling them to the attention of the American College of Obstetrics and Gynecology.

So, over a period of 4 or 5 years, by the dissemination of that information, obstetrical practice changed. The American College of Obstetrics and Gynecology came out with some standards based on these and other studies They are also coming up with another study about perinatal nutrition which should be provided in the neonatal intensive care units.

Well, I am obviously picking out one on which it is easier to tell a positive story but it is an example of what can be done.

Currently, one of the studies that is just being completed is being done by Ruth Stein in New York. She has been looking at how chronically ill and handicapped children can be cared for in a home setting with providers going into the home to deliver the services. And I think that that has the same possibilities of having an impact as the nutrition studies did once it's promulgated.

The ventilator-dependent infant, the high-technology type of children who are being cared for in hospitals at very expensive rates for long periods of time can, with the proper putting together of resources at the community level, be taken care of at home, not only less expensively but in a more humane fashion.

But it goes beyond the report of the research project; something has to be done in the next steps that follow.

Senator **Durenberger**. We have a lot of very good foundations in America, a number of them committed to health care and particularly in the area of obstetrics and pediatrics, and so forth. Where is all of the work in this area gathered together? Is it in your shop, or someplace else?

Dr. **Hutchins**. Well, sometimes in ours, sometimes in the foundations. The one that you mentioned in the Louisiana parish is actually a combination of the improved pregnancy outcome projects that were funded out of our office for the last few years to work on regionalization of perinatal care and the Robert Wood Johnson Foundation which funded 10 States on top of that to work in rural areas—and one of them was in Louisiana. And that particular project which was shown in that TV program was the Robert Wood Johnson part of it. So it was a question of working together to get that kind of information out.

Sometimes it isn't always gathered together in one place, and that's part of what one has to do in order to make it available in a usable form to help providers, not only in the public sphere but in the private sphere.

Senator **Durenberger**. Well, perhaps this is an issue that we can explore, just to demonstrate to Dr. Graham that I do care about the $300 millions and $400 millions. And I know too that we often have to have ways to keep doctors alive wherever they are doing some of these studies.

I am not going to ask you to make that statement, but I know that in part that is one of the traditional functions of nationally based research.

But we have made a commitment to set aside 10 to 15 percent of the funds that we have appropriated for direct Federal support in this area, and I think at some point in this series of examining how we can improve title V we may want to ask you and perhaps others knowledgeable in this area to come in and help us deal with this subject in perhaps a more effective way, if we can.

I thank both of you for being here, and I appreciate your testimony a great deal.

[Dr. Graham's written prepared testimony follows:]

STATEMENT BY ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Mr. Chairman and Members of the Subcommittee

I am Dr. Robert Graham, Administrator of the Health Resources and Services Administration. I am accompanied today by Dr. Vince Hutchins, Director of the Division of Maternal and Child Health in our Bureau of Health Care Delivery and Assistance.

The GAO report of May 7 of this year has confirmed our belief that States moved expeditiously and effectively to implement the Maternal and Child Health Block Grant following the passage of P.L. 97-35 in August of 1981. As we have reported in the past, all 57 States and jurisdictions accepted this block grant in its first year of authorization. The GAO study we are focusing on today was targeted on 13 States in diverse geographical locations throughout the country. These States represent a mix of rural and urban, agricultural and industrial characteristics which typify the country as a whole. As such, it can be concluded that the findings reported by GAO are in the main applicable to all 57 States and jurisdictions.

In regard to the major conclusions of the report, we are gratified that they coincide with our own impressions of State implementation of the block. Serious concerns expressed by many prior to passage of the block law were that the reduced Federal funding level would result in major service cut-backs and that States would not find the local resources needed to maintain critical services to mothers, children and the handicapped. While the report indicates that total expenditures increased in most States, the authors are careful to point out that the availability of prior year Federal categorical dollars and the additional jobs bill funds awarded in 1983, also helped to stabilize funding through 1984. More importantly, perhaps, the report indicates that States availed themselves of the new block grant flexibility to modify some service priorities with minimal disruption to those services provided under the predecessor categorical programs. This is, of course, precisely the kind of policy discretion for States that the block grants are intended to provide. States should determine on their own what types of programs they will fund and at what levels.

Most State officials who participated in the study indicated they favored the block grant approach while about half of the interest groups interviewed expressed a preference for the old categorical program system. The report indicates that the block implementation resulted in increased involvement by State officials and increased public participation in the program decisionmaking process. Most States held executive and legislative branch meetings and established advisory committees to facilitate comment. These mechanisms often influenced MCH program decisions. We view these findings as further evidence of the positive effects of the block grant approach.

Committee staff have also asked that we detail uses of funds from the Federal set-aside program which is commonly referred to as SPRANS, that is, special projects of regional and national significance. Title V authorizes an annual set-aside of 10 to 15% of the funds appropriated for direct Federal support of projects in the five major areas: research, genetic diseases, training, hemophilia, and other special projects. In a given year we fund about 100 training projects including a number of multidisciplinary university-affiliated programs which focus on the special needs of the mentally retarded and/or otherwise handicapped child; we also support about 40 research projects, 45 genetic disease screening testing and counseling projects, 25 hemophilia diagnosis and treatment programs and some 120 projects which focus on improving the delivery of health services to mother, children and crippled children. In this last category we are currently supporting projects which relate to ventilator dependent children, pediatric juvenile arthritis, community based support for the handicapped, prenatal care for high risk groups and adolescent health behavior.

The GAO study stands as an important report which has documented the success of States in implementing the new MCH block grant with minimal disruption of services and effective expansion of their management and program responsibilities. In addition, expanded citizen and health professional participation and increased interest by State legislative bodies and State executives indicate implementation by the States of their responsibilities for a broadened MCH program development process. This movement, we believe, reflects acceptance of the block grant philosophy of overall States' accountability for the health of their people and of the necessity for wide involvement of the citizenry, health professionals and all appropriate elements of government. We are confident that the next 3 years will demonstrate even more fully the effectiveness and efficiency of State MCH block grant operation.

Senator DURENBERGER. Our next witness is Hon. Dale Bumpers, U.S. Senator from the State of Arkansas.

Dale, we admire your timing. [Laughter]

And we welcome you to the hearing. We look forward to your statement.

STATEMENT OF HON. DALE BUMPERS, U.S. SENATOR FROM THE STATE OF ARKANSAS

Senator BUMPERS. Mr. Chairman, thank you very much for holding this hearing. You know that this is an area in which I have long been involved, although not as deeply as Betty Bumpers has been involved in it. She is the immunization guru at my house; she is the one who peaked my curiosity about it and subsequently, of course, in the MCH programs.

I would like to offer my statement for the record in its entirety, because I will not give it all, Mr. Chairman.

Senator DURENBERGER. It will be made part of the record.

[Senator Bumper's written prepared statement follows:]

STATEMENT OF SENATOR DALE BUMPERS
COMMITTEE ON FINANCE
JUNE 20, 1984

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE FINANCE COMMITTEE, LET ME BEGIN BY SAYING HOW PLEASED I AM TO HAVE THE OPPORTUNITY TO TESTIFY THIS MORNING ON AN ISSUE OF NATIONAL CONCERN, THE HEALTH AND WELL-BEING OF AMERICA'S MOTHERS AND CHILDREN. ALTHOUGH THE EXPRESS PURPOSE OF TODAY'S HEARING IS TO REVIEW THE FINDINGS OF THE RECENT GAO REPORT ON THE MATERNAL AND CHILD HEALTH BLOCK GRANT, I HOPE THE COMMITTEE WILL ALSO CONSIDER THE DEVASTATING IMPACT OF THE BUDGET CUTS ON MATERNAL AND CHILD HEALTH CARE THAT ACCOMPANIED THE BLOCK GRANT. EVEN THOUGH STATES HAVE BECOME INCREASINGLY EFFICIENT AND EFFECTIVE IN DELIVERING SERVICES, THEY ARE NOT IN A POSITION TO MAKE SERVICES AVAILABLE TO ALL THOSE IN NEED. MR. CHAIRMAN, WE

CANNOT VIEW THE ADMINISTRATION AND MANAGEMENT OF THE MCH BLOCK GRANT IN ISOLATION FROM THE CUTBACKS IN FUNDING, NOT ONLY IN FUNDS FOR THE BLOCK GRANT BUT FOR MEDICAID. OUR CHILDREN'S HEALTH IS IN JEOPARDY, AND IF THE FUNDING PRIORITIES OF THIS ADMINISTRATION CONTINUE, THEIR VERY LIVES WILL BE IN PERIL.

I MUST CONFESS THAT I HAD SOME MISGIVINGS ABOUT THE BLOCK GRANT FUNDING MECHANISM FOR MCH PROGRAMS. STATE HEALTH OFFICIALS ASSURED ME THAT THE QUALITY OF THE SERVICES PROVIDED WOULD NOT DECLINE AND THAT THE BLOCK GRANT WOULD ALLOW FOR THE MORE EFFICIENT AND EFFECTIVE USE OF RESOURCES. IT APPEARS THAT WHILE THE MCH BLOCK GRANT IS NOT WITHOUT ITS PROBLEMS, THE STATES HAVE TAKEN THE NECESSARY STEPS TO ENSURE THE CONTINUITY OF PRIMARY AND PREVENTIVE HEALTH CARE PROGRAMS AND TO ENHANCE THE QUALITY OF THOSE SERVICES. THE STATES INCLUDED IN THE REPORT HAVE DEMONSTRATED CONSIDERABLE SKILL IN ADMINISTERING THE BLOCK GRANT. THEY USED THE

OCCASION OF THE BLOCK GRANT MANDATE TO RETHINK PROGRAM PRIORITIES AND TO REFOCUS ASPECTS OF PROGRAM SERVICES. THE FLEXIBILITY GAINED THROUGH THE BLOCK GRANT FUNDING MECHANISM ALLOWED STATES TO MINIMIZE THE ADVERSE EFFECTS OF THE BUDGET CUTS IN MCH BLOCK GRANT FUNDING. I AM PLEASED TO SAY THAT ARKANSAS MAY BE CONSIDERED ONE OF THE MCH BLOCK GRANT SUCCESS STORIES. YOU WILL HEAR MORE ABOUT WHAT WE HAVE ACCOMPLISHED IN OUR STATE FROM THE PERSON WHO DIRECTS OUR STATE PUBLIC HEALTH PROGRAMS, DR. CHARLES MCGREW, LATER THIS MORNING.

I DO NOT WANT TO MAKE LIGHT OF THE RESOURCEFULNESS OF STATE PUBLIC HEALTH AGENCIES, OR THEIR ADMINISTRATIVE AND MANAGEMENT SKILLS. I AM HERE TODAY TO TALK ABOUT THE OTHER SIDE OF THE COIN, OR WHAT THE GAO CALLS THE BLOCK GRANT AS A BUDGET-CUTTING MECHANISM. I AM HERE TO DISPELL ANY ILLUSION THAT THE ADMINISTRATION MIGHT HAVE ABOUT THE SUDDEN WINDFALL STATES HAVE ENJOYED AS A RESULT OF COST-SAVINGS MEASURES

INSTITUTED BECAUSE OF THE BLOCK GRANT. THE ADMINISTRATION HAS ARGUED THAT THE ADMINISTRATIVE SAVINGS BROUGHT ABOUT BY THE BLOCK GRANT WILL OFFSET THE CUTS IN FUNDING. THE PROBLEM WITH THAT, MR. CHAIRMAN, IS THAT IT IS NOT THE CASE.

INDEED, THE BUDGET CUTS IN MCH, ON TOP OF BUDGET CUTS IN MEDICAID, HAVE TAKEN THEIR TOLL ON THE STATES. TRAGICALLY, THESE CUTBACKS HAVE OCCURRED DURING A PERIOD OF INCREASED DEMAND FOR SERVICES. WE HAVE SEEN A SIGNIFICANT RISE IN THE NUMBERS OF AMERICANS LIVING IN POVERTY, AN INCREASE OF 32% IN THE LAST FOUR YEARS. THERE ARE 34.4 MILLION LIVING IN POVERTY, NEARLY 40% OF WHOM ARE CHILDREN. ONE IN EVERY FOUR CHILDREN LIVES IN POVERTY. WHAT DO THE POOR DO FOR HEALTH CARE? WHERE DO PREGNANT WOMEN GO FOR PRENATAL CARE? WHERE DO INFANTS AND TODDLERS GET THEIR IMMUNIZATIONS? THEY DEPEND UPON PROGRAMS SUPPORTED BY THE MCH BLOCK GRANT AND MEDICAID. AND YET WE HAVE SEEN A 33% CUT IN THE AUTHOR-

IZATION LEVEL FOR MCH, AN ACTION CORRECTED IN PART BY THE RECENT RECONCILIATION BILL WHICH INCLUDED AN INCREASE IN AUTHORIZATION TO $478 MILLION. HOWEVER, THIS IS BELOW THE 1981 LEVEL OF $558 MILLION FOR THE EIGHT CATEGORICAL PROGRAMS CONSOLIDATED INTO THE BLOCK GRANT. THE PROGRAM HAS SUFFERED AN 18% REDUCTION IN APPROPRIATIONS. THE IRONY IS THAT MCH BLOCK GRANT IS OFTEN PERCEIVED AS THE STOP GAP MEASURE OFFSETTING THE DEEP CUTS IN MEDICAID. BUT HOW CAN WE EXPECT THE MCH BLOCK GRANT, MODESTLY FUNDED AT $399 MILLION THIS PAST YEAR, TO COVER THE 700,000 CHILDREN THROWN OFF THE MEDICAID ROLLS BECAUSE OF CHANGES IN ELIGIBILITY REQUIREMENTS? HOW CAN WE EXPECT THE MCH BLOCK GRANT TO COVER THE COSTS OF PRENATAL CARE FOR WOMEN PREGNANT FOR THE FIRST TIME OR POOR PREGNANT WOMEN WHOSE SPOUSE IS UNEMPLOYED? HOW CAN WE EXPECT STATES TO CONTINUE TO ABSORB THE RISING COSTS OF MATERNAL AND CHILD HEALTH CARE?

WE SOMETIMES HAVE DIFFICULTY GRASPING THE CONCEPT BEHIND LONGTERM COST EFFECTIVENESS PROGRAMS LIKE MCH. PREVENTIVE AND PRIMARY HEALTH CARE SERVICES ARE COST EFFECTIVE BECAUSE THEY REDUCE THE NEED FOR MORE COSTLY SERVICES IN THE FUTURE. FOR EXAMPLE, WE KNOW THAT PRENATAL CARE REDUCES THE RISKS OF INFANT MORTALITY AND MORBIDITY. WE KNOW THAT IT COSTS $1,500 TO PROVIDE COMPLETE PRENATAL AND DELIVERY SERVICES TO PREGNANT WOMEN. ON THE OTHER HAND, IT COSTS $1,000 A DAY TO PROVIDE INTENSIVE NEONATAL CARE FOR A PREMATURE INFANT AND IT COSTS BETWEEN $500,000 AND $1 MILLION FOR A LIFETIME OF INSTITUTIONALIZED CARE FOR A CHILD BORN HANDICAPPED. THE BOTTOM LINE IS THAT COST SAVINGS MEASURES LIKE BUDGET CUTS TAKE EFFECT IMMEDIATELY, AND SAVINGS THROUGH INVESTMENTS IN PREVENTIVE HEALTH CARE PROGRAMS ACCRUE IN THE FUTURE.

WE HAVE HEARD THAT MCH IS A STATE AND LOCAL ISSUE, THAT FEDERAL INITIATIVES ARE INAPPROPRIATE, INEFFECTIVE, AND INEFFICIENT. THE RESULTS OF THE GAO REPORT SUGGEST THAT IS NOT THE CASE. IN ARKANSAS, WE USED THE ADDITIONAL FUNDS MADE AVAILABLE THROUGH THE JOBS BILL LEGISLATION TO SERVE A 13 COUNTY AREA WHERE PREGNANT WOMEN PREVIOUSLY HAD HAD NO PLACE TO GO. WE HAVE HEARD THAT THE RECOVERY IN THE ECONOMY SHOULD LEAD TO A DECLINE IN THE DEMAND FOR MCH PROGRAM SERVICES. THIS ARGUMENT IS SPECIOUS: NO UPTURN IN THE ECONOMY WILL SHORTEN THE FIVE WEEK WAITING PERIOD IN THE PULASKI COUNTY MATERNITY CLINIC. ONE-HALF OF THE PREGNANT WOMEN WHO COME FOR SERVICES ARE TURNED AWAY BECAUSE THEY ARE EXPECTED TO DELIVER BEFORE THEY WOULD GET IN TO SEE A PHYSICIAN.

WHILE I APPLAUD THE EFFORTS OF STATE HEALTH CARE OFFICIALS LIKE ARKANSAS' CHARLES MCGREW, TO MAKE DIFFICULT DECISIONS ABOUT FUNDING PRIORITIES, I AM DISTURBED BY THE KINDS OF DECISIONS WE HAVE FORCED THEM TO MAKE. WHY DO WE PUT STATES IN THE POSITION OF HAVING TO DECIDE WHICH OF A CHILD'S HEALTH NEEDS ARE MOST IMPORTANT? WE ASK STATES WHICH IS MORE IMPORTANT: SUDDEN INFANT DEATH PROGRAMS OR THE SERVICES OF AN AUDIOLOGIST? HOW COULD WE ALLOW A SITUATION TO DEVELOP WHERE THE SERVICES OF MATERNITY CLINICS ARE AVAILABLE IN SOME COUNTIES BUT NOT IN OTHERS? AT LEAST, THESE ARE THE KINDS OF QUESTIONS WE HAVE HAD TO RESOLVE IN ARKANSAS.

STATES HAVE ACTED VERY RESPONSIBLE ABOUT THEIR HEALTH CARE PROBLEMS AND BUDGET CONSTRAINTS. MANY STATES HAVE RAISED TAXES TO BALANCE THEIR BUDGET AND TO ENSURE ADEQUATE

FUNDING FOR HEALTH CARE PROGRAMS. IT IS TIME FOR CONGRESS TO REDEFINE OUR PRIORITIES, TO CONTINUE PROGRAMS THAT WE BELIEVE ARE JUST, FAIR, AND COST-EFFECTIVE. IF WE FAIL TO PRESERVE THE INTEGRITY OF THESE PROGRAMS, WE WILL ONLY BEAR GREATER COSTS LATER. THE MCH BLOCK GRANT IS THE ONLY HEALTH CARE PROGRAM EXPLICITLY FOR CHILDREN. THE IMPACT OF THE BUDGET CUTS HAS BEEN DEVASTATING. SELDOM DO WE SEE SUCH STARK AND TERRIBLE RESULTS FROM OUR IMPRUDENT ACTIONS.

MR. CHAIRMAN, IN CLOSING LET ME SAY THAT THIS IS ONE OF THE BEST FEDERAL PROGRAMS WE HAVE. WE HAVE A MORAL OBLIGATION TO INSURE TO THE MAXIMUM EXTENT POSSIBLE THAT EVERY CHILD HAS A HEALTHY START IN LIFE. IT IS UNCONSCIONABLE THAT IN ANY ERA WHEN SO MUCH CAN BE DONE TO PREVENT NEEDLESS PAIN AND SUFFERING ON THE PART OF MOTHERS AND CHILDREN, THAT WE DO SO LITTLE. I AM HEARTENED BY THE NUMBER OF MY COLLEAGUES WHO HAVE JOINED ME IN THE FIGHT TO SECURE ADEQUATE FUNDING FOR THIS PROGRAM. I AM HOPEFUL THAT WE WILL BE ABLE TO FULLY FUND THE PROGRAM AT THE AUTHORIZATION LEVEL AND THAT THE STATES WILL FINALLY HAVE THE STABILITY AND CONTINUITY IN FUNDING THEY DESERVE.

Senator **Bumpers**. I know that we are here to review the findings of the recent GAO study on the maternal and child health block grant and the effects it has had on the States. The States have become more efficient because of the block grants and the necessity for cutting back on certain programs. They have also had to rethink their positions and establish priorities.

I had misgivings about the block grant funding in the beginning, but the State officials assured me that the quality of the services provided wouldn't decline, and that the block grant would allow for the more efficient and effective use of resources. It appears that while MCH block grants are not without their problems, the States have taken the necessary steps to assure the continuity of primary and preventive health care programs and to enhance the quality of those programs. The States included in the GAO report have demonstrated considerable skill in administering the grant.

Mr. Chairman, I don't want to make light of the resourcefulness of State public health agencies or their administrative and management skills; I am here to talk about the other side of the coin, or what GAO calls "the block grant as a budget-cutting mechanism."

As I said a moment ago, I had strong misgivings about the whole block grant concept as an efficient method of cutting costs without reducing efficiency of the delivery of services. I am here to dispel any illusion the administration might have about the sudden windfall States have enjoyed as a result of cost-cutting measures which have been instituted because of the block grant concept.

The administration has argued that the administrative savings brought about by the block grant will offset the cuts in fundings. That is nice to hear. The unfortunate part of it is that it simply is not true. Rather, the budget cuts in Maternal and Child Health programs, on top of budget cuts in medicaid, have taken a terrible toll upon the States. It is tragic that these cutbacks have occurred during a period of increased demand for services.

We have seen a significant rise in the numbers of Americans living in poverty, an increase of 32 percent in the past 4 years. There are 34.4 million people living in poverty, nearly 40 percent of whom are children. One of every four children in the United States lives in poverty.

What do the poor do for health care? Where do pregnant women go for prenatal care? Where do infants and toddlers get their immunizations? Well, I can tell you they depend on programs supported by MCH block grant and medicaid. And yet, we have seen a 33-percent cut in the authorization level for MCH, an action which admittedly has been corrected in part by the recent reconciliation bill, which included an increase in the authorization—not the appropriation but the authorization—to $478 million. But this is well below the 1981 level of $558 million for the eight categorical programs consolidated into the block grant. The program has suffered an 18-percent reduction in appropriations. The irony is that the MCH block grant is often perceived as a stopgap measure offsetting the deep cuts in medicaid.

Now, how can we expect the MCH block grant, modestly funded at $399 million this past year, to cover the 700,000 children thrown off the medicaid rolls because of the changes in eligibility in that program? How can we expect the MCH block grant to cover the cost of prenatal care for pregnant women for the first time, or poor pregnant women whose spouses are unemployed? How can we expect States to continue to absorb the increasing demand for and rising costs of maternal and child health care?

We sometimes have difficulty grasping the concept behind long-term cost-effective programs like MCH. Preventive and primary health care services are cost-effective because they reduce the need for more costly services in the future.

Example: We know that prenatal care reduces the risk of infant mortality and morbidity. We know it costs $1,500 to provide complete prenatal and delivery services to pregnant women.

On the other hand, it costs $1,000 a day to provide intensive neonatal are for a premature infant, and it costs between $500,000 and $1 million for a lifetime of institutionalized care for a child born handicapped. Why do such cost-effect programs like MCH suffer cutbacks in funding? Well, the bottom line is that cost-saving measures like budget cuts take effect immediately, and savings through investment in preventive health care programs accrue in the future.

We have heard that MCH is a State and local issue, that Federal initiatives are inappropriate, ineffective, and inefficient. The results of the GAO report suggest that this is not the case. I know in Arkansas we used the additional funds made available through the jobs bill legislation to serve a 13-county area where pregnant women previously had no place to go.

We have heard that a recovery in the economy should lead to a decline in the demand for MCH program services, and that argument is specious. No upturn in the economy will shorten the 5-week waiting period in the Pulaski County Maternity Clinic in my State. One-half of the pregnant women who come for services are turned away because they are expected to deliver before they would get in to see a physician.

While I applaud the efforts of State health care officials like Arkansas' Charles McGrew to make difficult decisions about funding priorities, I am intensely disturbed by the kinds of decisions we force them to make.

Why do we put States in the position of having to decide which of a child's health care needs are important? We ask States: Which is more important, Sudden Infant Death Syndrome Programs, or the services of an audiologist? How could we allow a situation to develop where the services of maternity clinics are available in some counties but not in others? At least these are the kinds of questions that we have had to resolve in my State.

States have acted very responsibly about their health care programs and budget constraints, and many States have raised taxes to balance their budgets and to ensure adequate funding for health care programs. It is time for Congress to redefine its priorities, to continue programs that we believe are just, fair, and cost-effective.

If we fail to preserve the integrity of these programs, we will only be building costs for later. The MCH block grant is the only health care program explicitly for children. The impact of the budget cuts have been devastating. Seldom do we see such stark and terrible results from our imprudent actions here.

Mr. Chairman, in closing let me say that this was one of the best Federal programs we had. We have a moral obligation to ensure to the maximum extent possible that every child has healthy start in life. It is unconscionable that in any era when so much can be done to prevent needless pain and suffering on the part of mothers and children that we do so little.

I am heartened by the number of my colleagues who have joined me in the fight to secure adequate funding for the program, and I am hopeful we will be able to fully fund the program at the authorization level, and that the States will finally have the stability and continuity in funding that they richly deserve and need.

Thank you very much, Mr. Chairman.

Senator DURENBERGER. Dale, let me ask you—well, the usual thing you get from all of us, part comment, part question—a question:

If you adopt the theory that maybe $478 million isn't enough to accomplish the objectives that you and I share, and maybe $1 billion is more adequate, you also have to adopt the notion that that money is going to go out on a landscape that has a variety of capacity to address the problem.

We have heard so far this morning, and I expect that we will hear from some of the State representatives, giving them at least the feeling that it is more their program than ours is helpful in the decisionmaking process. But I suspect they will acknowledge what you said in your statement about the unevenness of the resource base from State to State and from county to county within the State.

But what we have traditionally done here, and you were practicing it before I got here, and I guess I picked up the practice from lots of other people, that to make it even we just raise the level of the ocean, so that there is no more resource demand on the so-called rich county; it's just that Federal money fills in the gaps for the poor counties.

A lot of people will tell us that that's not necessarily an efficient utilization of resources we don't even have here. Others will say that that kind of response doesn't necessarily get at the direct care versus preventive care, either.

So one of the things that I'm struggling with here, in terms of looking at one of the best, oldest programs we have in the country, almost 50 years old now, is is there a way to do this whole Federal partnership that we have been talking about here this morning in a way that isn't just a so-called financial drain, but has in it the best of all of these worlds?

I don't know if you have any thoughts you want to share with me now, but I said in the beginning that it's my view that for the 5 years I have been on this committee we have just come back to this block grant as a budget process. I call this a "block grant" because it really, literally has been one, and we add a little money or take some money out, or something like that.

I would really like to look at revising title V in some appropriate way and would certainly look to you as someone who has been committed to this program longer than I for some advice on how we might make the Social Security Act more effective.

Senator **Bumpers**. Mr. Chairman, I really appreciate your comments, and you have obviously given this a lot of thought. You are very perceptive about what we ought to be doing, and I couldn't agree with you more about reassessing the whole thing.

First of all, I never did like the block grant concept in health programs. I think that the President was probably right in some areas in the original block grant concept, when he first became President. I thought that we could cut administrative costs rather dramatically and get more money to the programs that we had targeted.

But I never did like the idea of the block grant concept where health care is concerned.

Now, I would just like to undo health care block grants and target the money where we know the need is present.

Let me give you a couple of examples: In my State we have absolutely cut medicaid eligibility rules to the point, because we have been cut back so dramatically here, and it is going to be devastating over the next 3 years—medicaid in my State.

You may remember that we had a rather lengthy colloquoy in which I think you participated on the floor a couple or 3 weeks ago on this very point.

But now, in my State, let's take a poor child who is born with a congenital heart defect, and let's assume that he or she is an AFDC child who is normally eligible for medicaid services. We have cut those services so that that child with a congenital heart defect, which might require as much as 2 to 3 months hospital care, and intensive hospital care at that, gets 9 days. Nine days is the limit. And it is through these maternal and child health care programs that we pick up that extra tab, because medicaid will only pay for the first 9 days under Arkansas' rules.

You know, we have a lot of latitude at the State level about what you are going to do to try to come in within the money, and we just cut eligibility rules until it is unbelievable.

And we have crippled children's clinics in my State. And we have a lot of screening programs—all funded by MCH.

Now, my point is this: It seems to me, No. 1—medicaid, incidentally, has no constituency. You are not going to get the U.S. Senate excited about putting money in a medicaid program, because you know who those people are; they don't have any lobbyists standing out here.

Now, as you know, when the Finance Committee is on the tax bill I can't walk from my office down this hall. But if you are talking about medicaid, and trying to provide for some infant being born of a poor family in Arkansas, you won't see a single soul out there, as you don't right now. There is no constituency for these people except a few sensitive and concerned people—and I like to think you and I are sensitive and concerned about this, or we wouldn't be here.

But I am saying that those programs ought to be targeted. We just shoot ourselves in the foot with this. No child should be deprived of that kind of care—crippled children's screening clinics, congenital heart defects, or whatever. And the 700,000 children in this country who have been kicked off the AFDC roles and are no longer eligible for medicaid services, when you consider the fact that in our State we have taken all children over 16 years of age off medicaid; whether their parents are on it or not, the child if it is over 16 is not eligible.

I guess I am sort of rambling around.

Senator **Durenberger**. No.

Senator **Bumpers**. But the point I want to make is this: We ought to target each one of those programs.

Now, children do have a constituency; no politician has ever been defeated championing the rights of children—their health care, or anything else. And so they have a great constituency. But there is more to it than that.

MCH and childhood immunizations are easily the most cost-effective programs, the most cost-effective health programs in this country.

As you know if you have studied this MCH thing, and I am sure you have, the State of Mississippi says for every dollar they spend on the MCH programs in that State they save $11. Alabama says $10. You can go through every State in the country, and you'll find the cost-benefit ratio is very high.

On childhood immunizations, after Betty and Joe Califano finished up that national immunization program in 1980 and had their big press conference to say, "We now have 96 percent of the children in this country immunized against preventable childhood diseases," Joe Califano said "the cost savings of this immunization program is estimated to be $15 billion a year—not just in medical costs but in days work by mamas and papas who would otherwise have to stay home with a sick child."

So all I am saying is that we continue to shoot ourselves in the foot for programs that, on the scheme of things around here, are very inexpensive.

Senator **Durenberger**. I thank you very much.

Senator **Bumpers**. Thank you, Mr. Chairman.

Senator **Durenberger**. I won't keep you any longer.

Let me introduce the next panel:

Sara Rosenbaum, Director of Child Health, Children's Defense Fund; Dr. Don Blim on behalf of the American Academy of Pediatrics; and Dr. Richard Nelson, Department of Pediatrics, University of Minnesota, and Medical Consultant to the Crippled Children's Program, Minnesota Department of Health.

Let me ask that all of you and the subsequent panel have in mind the real-life problem that Dale alluded to and that we now have given a name to as The Society of the So-called Corridor Poor. It is that large growing category—I hate to use that phrase, but it is all those folks who are not covered by insurance, either public or private. And, as Dale indicated, they are a growing number in the last several years.

I would be curious to know what some of the States and other areas are doing to cope with that part of the problem as well.

Sara, let's start with you, and I appreciate all of you being here. Your full statements will be made a part of the record, and you may summarize.

STATEMENT OF SARA ROSENBAUM, DIRECTOR, CHILD HEALTH, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Ms. **Rosenbaum**. Thank you, Mr. Chairman.

The Children's Defense Fund is very pleased to have been invited to come testify today, and we do have a longer statement for the record, which I will summarize now.

Senator Bumpers so eloquently laid out the problem of children in poverty that I won't go over those statistics again. We all know that poverty itself is associated with diminished health status, so we are not only concerned about the large number of children in poverty but should be equally concerned that those children and their mothers, of course, will be in significantly poorer health.

We also know about the major gaps in health insurance in the United States. Thus, in examining title V one has to do so within the context of the modest program that title V actually is.

The uninsured, according to recent statistics, receive about 90 percent less hospitalization and about 55 percent less physician services than do the insured. And given the poor health status of low-income families, that's a very serious gap.

We are in the process now at the Children's Defense Fund of looking at programs for uninsured mothers and children in 25 States thoughout the country.

For the past several years we have done periodic surveys of maternal and child health issues. A list "Children and Federal Health Care Cuts," surveyed all 50 States over a 6-month period. We decided to intensively look at about 25 States this year. While the survey results aren't final yet, I would like to share with you some of what we found to date.

One of the States we surveyed was Texas. The information that we have comes from State and county health officials, as well as a great deal of supporting documentation sent to us. State officials estimate that there are about 90,000 poor pregnant women living in Texas. Sixty-one thousand women were seen through health department clinics last year. The Medicaid Program in Texas paid for only about 14,000 deliveries, however, which left probably well over 30,000 deliveries unpaid for.

Many local hospitals in Texas now require women to pay substantial preadmission deposits in order to register for delivery at the hospital. Needless to say, most of these women don't have a personal obstetrician. They come to a hospital wanting to register for delivery, and they are told they have to pay $200, $500, $1,000 up front to cover the delivery.

Senator **Durenberger**. Where do those figures come from?

Ms. **Rosenbaum**. The figures are actual preadmission deposit figures from hospitals.

Senator **Durenberger**. From Texas?

Ms. **Rosenbaum**. Yes, from Texas. And the figures also apply in Mississippi, which is another State we have looked at. In fact, the figures can be as high as $1,800 preadmission deposit requirements.

Now, I don't walk around with $1,800 in my pocket, much less in my bank account, and I'm sure many of us don't. Of course, these families certainly do not. For some of them, $1,800 may represent their entire income for a quarter of the year. Of course, they don't have the preadmission deposit, which means that some of them are forced to show up when they are actually in labor and hope that the hospital at that point is a Hill-Burton facility and therefore obligated to admit a woman in labor, at least until her condition was stabilized and she has delivered the child, or is perhaps responding to the State's emergency care laws and will provide her some emergency care.

Texas officials told us, though, that a lot of these women don't even do that, and that the State right now leads the Nation in the number of out-of-hospital births. Last year Texas accounted for one-third of all the Nation's out-of-hospital births.

Now, there are those of us who are middle-class people who decide, for various reasons, to have an out-of-hospital birth. That is not the context in which these out-of-hospital births are occurring; they are occurring to women who are too poor to register, who could not make it to the hospital in labor, who are delivering at home unattended.

Last year the State had to use half of its emergency Jobs Act moneys not to expand maternity services into 17 of the 72 city and county health departments that still don't offer any maternity services, but to give women preadmission deposits so that they could hopefully register to deliver their babies. This is a pitiful use of maternal and child health funds, given the modest nature of the program.

Similarly, in Louisiana where, as you know, there has been a very successful improved pregnancy outcome project, the State has used that IPO money and some of the MCH block grant fiscal 1983 supplemental funds to expand and improve maternity and pediatric services in many of the parishes around the State. They were able to improve their maternity caseloads by 34 percent and their pediatric caseloads by 12 percent. In the parishes served by the IPO project officials have been able to cut their mortality rates from 24.9 deaths per 1,000 live births to a provisional rate of 14.9 deaths per 1,000 live births. But officials tell us they don't know what is going to happen when the DPO funds run out. The outreach worker whom you saw in the films—that person's job is either ending or has ended, and many of the expanded services are now ending as well.

In Minnesota, 51,000 families with children live below the poverty level. Medicaid, even in 1980, only reached about 40 percent of those children, and we know in 1982 an estimated 13,500 households lost their medicaid cards.

The State does have a community health services plan; however, we are told that the plan, which is in effect throughout the State, is not adequately financed to provide what I would call hands-on direct preventive services—prenatal care, specialized services for pregnant women who are high risk and routine sick-child care for young children. Mothers and children are told in many of these counties, that they have to make their own arrangements for that kind of care; they have to find a physician who is willing to treat them at little or no cost. I am sure that many of them find the physicians; many of them undoubtedly do not. And the ones who do not may wind up in the mortality statistics.

There are counties in some of these rural unserved Minnesota counties that show mortality rates as high as 21 deaths per thousand live births, which of course is double the national average.

We were particularly interested in the Mississippi segment of the GAO study, because as you may know we maintain an office in Mississippi and have for about 15 years. That office does a considerable amount of maternal and child health work.

The GAO wrote about the nurse-midwife maternity and infant care project in Holmes County, MS. It is a northern, very rural, very very poor county. The GAO noted that the project accounts for about 85 percent of the deliveries that are done in the county.

The project is now slated to close because of depleted funds. And GAO observed that the women are either going to have to depend on obstetricians, or travel for their care, or have home births.

In Holmes County, in fact, there are no obstetricians. There is not a single obstetrician in Holmes County, and so women then can't depend on an obstetrician. That is one of the reasons why the nurse-midwife project was put there to began with.

As far as traveling goes, the university medical center is 80 to 90 miles away from Holmes County, which makes it an unthinkable alternative for prenatal care, especially when we are talking about women who may have to go for weekly visits. Besides, the university is about to close its own nurse-midwife program serving the indigent. And as far as home births go, we know what dangers are attended with home births in these situations.

I should note that this is a time when Mississippi really ought to be thinking about expanding its programs rather than cutting them. The university medical center, which of course is the main provider in the State for the uninsured and was just taken over under a management contract by the Hospital Corporation of America, recently announced that it is planning to close many of its neonatal intensive care beds because of the large number of uninsured newborns whom it must serve and whom it claims it can't afford to cope with anymore—babies born to women with husbands who don't qualify for medicaid only because their husbands are home, babies who don't qualify for medicaid only because both parents are home. Their babies will potentially be unable to get into a newborn intensive care unit, after July 1.

At the same time, we are finding that out-county travel to give birth is happening at an alarming rate. In one Mississippi county, of 391 black births that occurred last year, 3 of them happened within the county and the other 388 women traveled to Memphis or down to Jackson because they couldn't afford the deposits at the county's hospital.

And 2 weeks ago, finally we had the report of an infant death. A girl, a 14-year-old pregnant girl who was uninsured. Arrangements had been made to transfer her into a Florence Crittenden Home in Jackson in her seventh month of pregnancy. Unfortunately, the girl went into premature labor at 6½ months. The mother brought the girl to a local hospital. The hospital said, "We will not admit the girl; she has no insurance." They told the mother to drive the girl 90 miles to Jackson. The drive of course took about 2 hours. The mother was—I can tell you—fortunate to have a car to even think about driving the girl to Jackson. The baby died *in utero* on the way.

In that context we have two general criticisms of the GAO study.

Senator **Durenberger**. Can you do them fairly quickly? I am really intrigued by your testimony, but we are short on time.

Ms. **Rosenbaum**. I'm sorry. One of them simply is that they tended to overlook some cuts. They minimized some cuts that they themselves reported. And the other was that they left unanswered the key question of whether there were other accessible services in the community.

We urge that the MCH block grant receive more money. However, it is clear that until there is a stable source of insurance for these people, MCH can't cope alone. We urge support for enactment of the Child Health Assurance Act now pending before the budget conferees.

Thank you.

Senator **Durenberger**. Thank you very much.

Dr. Blim?

[Ms. Rosenbaum's written prepared testimony follows:]

TESTIMONY OF SARA ROSENBAUM, DIRECTOR, CHILD HEALTH DIVISION, CHILDREN'S DEFENSE FUND

Mr. Chairman and Distinguished Members of the Subcommittee:

The Children's Defense Fund (CDF) is pleased to present testimony today regarding the status of the Maternal and Child Health (MCH) Block Grant. For over a decade, CDF, a national public charity, has devoted considerable resources to advocacy on the health issues affecting poor children. We have examined their unmet health needs and have also written extensively about the performance of the major federal health programs intended to meet those needs. We have focussed our efforts particularly on Medicaid and the Maternal and Child Health Block Grant program (both before and after its reauthorization in 1981).

In January, 1983, we issued a report entitled Children and Federal Health Care Cuts, a copy of which we have submittd for the record. In that report, we presented a "snapshot" of changes that had occurred in key maternal and child health programs during the year that followed enactment of the Omnibus Budget Reconciliation Act (OBRA). The study, which took approximately seven months to complete, identified changes in eligibility and coverage policies under maternal and child health programs that were reported to us by state health officials.

In January, 1984, we issued American Children in Poverty, a copy of which is also submitted for the record. American Children comprehensively examined recent trends in poverty among children and examined maternal and child health trends.

While it is important to monitor the performance of federal programs such as the Maternal and Child Health Block Grant, the results mean little unless they are placed in some context. Before specifically addressing GAO's findings regarding implementation of the MCH block grant, I would therefore like to provide some background on the underlying problem.

1. OVERVIEW OF POVERTY AND CHILD HEALTH: THE SCOPE OF THE PROBLEM

Today there are over 13 million poor children in America, a 31% increase in their poverty rate since 1979. This represents the sharpest poverty rate increase for children since poverty statistics have been collected. Today, one in every 5 American children is poor. One in every 2 black children is poor. Three quarters of all black children living with one parent are poor.

By almost any measure, moreover, poor children are in worse health than their wealthier counterparts. Poor children have 30% more days of restricted activity and lose 40% more school days because of illness. Their parents are more likely to report them as suffering from a chronic condition. Three to six times as many poor children are likely to be reported in fair to poor health, and poor chldren are 40-50% more likely than non-poor children to be found to have a significant abnormality on physical examination by a physician.

Mortality among children is significantly related to poverty. Neonatal mortality is 150% higher among poor children. Postneonatal death rates are 200% greater. After the first year of life, poor children are one and one-half to three times more likely to die than non-poor children. Perinatal problems, when they do occur, have a greater impact and more sequalae in poor children, and poor children have greater IQ deficits when born at low birthweight as other children.

There are indicators that over the past several years, health risks facing poor children have heightened:

- Babies born to mothers receiving late or no prenatal care are three to four times more likely to be low birthweight and three times as likely to die in the first year of life. Yet after nearly a 10-year period in which an increasing number of women began prenatal care early in their pregnancy, since 1980 this this trend has reversed itself, and there has been an upward climb in the percentage of women receiving little or no care.

In our recent study, American Children in Poverty, we collected and analyzed five years of vital statistics from 37 states, representing over 75% of all live births in 1980. Sixty-two percent of reporting states reported an increase in 1982 over 1981 in the percentage of women receiving little or no prenatal care. Among states reporting prenatal care data by race, 78% reported an increase in late or no prenatal care rates among nonwhite women. In ten states, the rate for late or no prenatal care among nonwhite women was the worst it had been in five years.

Based on these statistical trends, we found that 95% of reporting states would fail to meet the Surgeon General's 1990 goals for ensuring appropriate access to prenatal care. A majority of states can also be expected to fail to meet the Surgeon General's goals with respect to low birthweight and infant mortality rates, especially among nonwhite children. Assistant Secretary Brandt confirmed that the nation will fall short of these modest 1990 goals in recent testimony before the House Energy and Commerce Committee regarding nonwhite infant death rates in the United States.

- In addition to declining prenatal care indicators, in recent years there has been a decline in the percentage of preschool children who are adequately immunized against childhood disease. In 1978, 51.7% of black preschool children were not fully immunized against diptheria, pertussis and tetanus (DPT). By 1982 that figure had climbed to 66%. In 1978, 60.7% of black preschool children were not adequately immunized against polio. By 1982, the number had climbed to 65%.

Given the lowered health status of poor children, it is particularly alarming that the events of the past several years indicate, if anything, an ever-increasing pool of poor and uninsured children. By 1982, according to recent testimony presented before this Subcommittee by the Urban Institute, 38.6 million Americans under age 65, a one-third increase since 1979, were uninsured. Forty-percent of all the uninsurd, 15 million persons, were children. One in five American children was thus uninsured as of 1982.

Despite these grim statistics, federal health programs for children were cut back dramatically. Since 1981, over 700,000 children have lost Medicaid coverage, and hundreds of thousands more have been prevented from qualifying because of new and restrictive eligibility criteria. As we showed in American Children in Poverty, the percentage of poor children who now receive for Medicaid is the lowest since the program was first fully implemented. Furthermore, funding for the modest programs consolidated into the MCH Block Grant (the only residual health program for millions of uninsured children that is targetted spcifically at them) was cut by approximately 18% before inflation.

Even prior to 1981 there was a considerable gap between the unmet health needs of children living in poverty and the responsiveness of federal programs. Even in 1980, only 50% of poor children qualified for Medicaid. Two-thirds of all poor children were either never insured or else were insured for only part of the year. Yet for Fiscal 1984, the funding level for the Title V MCH Block Grant (even assuming some carryover funds from the emergency jobs act legislation), was $650 million below the amount needed to maintain the level of services provided during 1981, before inflation.

The Children's Defense Fund is currently in the process of evaluating the availability of maternity and pediatric services for uninsured, low income mothers and children in approximately 25 states. While final results of the survey are not yet available, it is already evident that none of the states we surveyed has been able to develop or maintain a stable and reliable system of adequate maternity and pediatric services for poor and uninsured women and children that assures them continuing access to appropriate maternal and child health services, including (and especially) needed hospital care. Indeed, numerous states report significant gaps between the amount of unmet maternal and child health need and their ability to respond:

- There are an estimated 90,000 poor pregnant women living in Texas at or below 150% of the federal poverty level. Sixty-one thousand women were seen through health department clinics last year. Medicaid paid for only 14,095 deliveries, however, leaving approximately 36,000 deliveries to a predominantly uninsured population.

  Many local hospitals in Texas now charge substantial preadmission deposits for a pregnant woman who wishes to register at the hospital for delivery of her child. Preregistration is, of course, crucial, so that a hospital and the attending physician can be alerted as to whether the patient presents a high risk of delivery complications (most of these women have no personal obstetrician to deliver their babies, since they are indigent).

Because the preadmission deposit requirements are so prohibitive, however, a large number of births happen outside of the hospital. In 1982, Texas alone accounted for one-third of all out-of-hospital births in the United States. Women who do not deliver at home (unattended by an obstetrician, since they cannot afford one) wait until they are in labor to present themselves at the nearest hospital as an emergency case. Last year, Texas used half its Jobs Act supplemental MCH Block Grant appropriations, not to improve preventive services, (approximately 17 of 72 city and county health departments and one regional health department still do not offer any maternity care) but to underwrite hospital delivery costs forsome of the pregnant women who had no Medicaid. When those monies run out, the delivery program will cease.

- Special infusions of funds in Louisiana through the Title V Improved Pregnant Outcome (IPO) Program and the Fiscal 1982 Jobs Act supplemental appropriation made it possible for state and local health officials to deliver important new services to poor women and children. Because of IPO funds, mortality rates in Tangipahoa County dropped from 24.9 deaths/1000 live births in 1978 to a provisional rate of 14.9 deaths/1000 live births in 1982. Similarly, clinics throughout the state were able to increase their maternity caseloads by 34% and their pediatric caseloads by 12%.

But the IPO and Jobs Act funds are now running out. When they do, the lay outreach workers and extra clinicians who made these services and results possible will be gone.

- In Minnesota, about 51,000 families with children (1/3 of all such families) live below the federal poverty level. Yet Medicaid coverage in Minnesota reached only about 39% of poor children in 1980. Moreover, in 1982, because of the federal budget cuts, the University of Minnesota estimates that more than 13,500 households lost Medicaid eligibility. Since heads of households in these cases tend to work at marginal jobs with little or no employer-paid health insurance, they are often wholly dependant on public health services.

The state has developed a Community Health Services plan which covers most areas of the state for well child care, public health nursing home visits and health education. Despite these very basic services, state MCH officials report that in rural counties, which comprise 50% of the state, all sick-child and maternity medical services are provided by private physicians. Families are required to make their own arrangments with physicians. In 1980, infant mortality rates in some of these counties were as high as 21 deaths per 1000 live births, twice the national average.

- In Kansas, 7.6% of all families in the state live in poverty. Yet the state's Maternity and Infant Care Projects reached only 2.7% of women giving birth in 1982. State officials reported incidents in which indigent women were denied prenatal care because of outstanding medical bills. Jobs Act funds were used last year to expand preventive services in 52 counties that showed the largest numbers of births to poor women in 1982. Even those funds, however, would not cover hospital and obstetrical costs at the time of delivery. County officials do not know what will happen to these modest programs when the Jobs Act monies run out.

II. Analysis of the GAO Report

In our opinion, the GAO report substantially confirms our own conclusion that preventive maternal and child health services for mothers and children under the block grant have suffered in recent years. First, according to the audit performed by GAO, most states experienced a real-dollar decline in total expenditures for maternal and child health-related services. Moreover, the only reasons that the reductions were not deeper were: 1) consolidation of various federal categorical programs into the MCH block grant that temporarily inflated some state MCH operating budgets; 2) carryover funds from Fiscal 1981 and the one-time Fiscal 1983 supplemental appropriation mitigated the loss of funds. In no state, however, did real dollar growth for MCH services approach the growth in childhood poverty rates mentioned above.

Second, the GAO report describes the very troublesome decision-making that confronts state health officials faced with too much need and too few resources. Since none of the services financed under the MCH block grant could possibly be considered unnecessary, states have logically continued to support most of what had been funded previously. MCH officials were virtually unable to deal effectively with the widespread need among uninsured mothers and infants for assistance with hospital-related costs.Certain preventive services, moreover, including lead-based paint poisoning prevention, SIDS, and the programs of projects were cut heavily, apparently in order to spread funds a little further.

According to GAO, cuts were certainly not made because SIDS or lead poisoning problems were not present; officials indicated instead that the service was a "low priority" or that they thought that a child could obtain the same service elsewhere. One of the most ironic responses came from California MCH officials, (Report, p. 47) who apparently justified discontinuing the lead screening program because lead poisoning treatment services were available through the state crippled children's services program.

The fate of the old Title V programs of projects bears special attention because it has been particularly tragic. No federal investment has a prouder track record than these projects. Repeated studies have shown that they have led to dramatic declines in prematurity, low birthweight and mortality rates among infants, as well as a reduced incidence of childhood illness. Yet between 1981 and 1983, according to GAO, funding for these projects declined by 21%. Twelve of the 13 states surveyed either reduced or eliminated these projects.

Seven percent of the projects were eliminated outright. Some of the projects most deeply affected provided the very services that are the most difficult to obtain on a free or reduced cost basis, especially dental services, comprehensive maternity care, intensive infant care, and pediatric services for acute and episodic illnesses.

Because we do extensive work in Mississippi, (where we maintain a state office) we examined the Mississippi program of project reductions particularly closely. GAO's review of Mississippi's maternity and infant care project reductions (page 39) concludes by noting that, if a special nurse midwife project providing maternity care for indigent women closes, the women will have to rely on private obstetricians, travel to the University Hospital (80 miles away), or resort to home deliveries. The first option (reliance on private obstetricians) is not an option for these MIC patients. In Holmes County, where this project is located, there are no obstetricians at all. The women in that county are completely dependent on the MIC program. (GAO notes that the project accounts for 85% of all deliveries in the county.) The second option, travelling to the University of Mississippi Medical Center, is an impossible and unsafe alternative because of the great distance. Furthermore, the University's own nurse midwife program is to be defunded as of June 30, so that services will be drastically reduced. Finally, the third option, home births, would obviously be disastrous for these women, many of whom are high-risk and none of whom would be able to be attended by an obstetrician. Given the very high mortality rates in Holmes County even with a nurse midwife program (20.1 deaths per 1000 nonwhite live births in 1982), resorting to unattended home births is unthinkable.

This is a time when Mississippi officials need to expand services, not cut them. The University Medical Center, the only source of care for many of the state's poor, and just taken over by the Hospital

Corporation of America under a management contract, is threatening to start denying admission to uninsured sick newborns Last year, all but 3 of 394 Black births in one Mississippi county occurred out-of-county because poor women in that county could not afford to get into the hospital in the county. They travelled up to nearly 100 miles to find a hospital that would admit them. And two weeks ago, a 14-year-old pregnant girl who went into premature labor and lost her baby *in utero* when the local hospital refused to admit her because she was uninsured. When she arrived at the hospital she was told that because she had no health inurance, her mother would have to take her to Jackson, a 90 mile trip, for delivery. The baby died on the way.

We have two general criticisms of the GAO study which are especialy relevant to the agency's discussion of available services. First, the investigators, in our opinion, tended to minimize and obfuscate some serious cuts. For example, GAO notes (page 29) that "no state reported dropping any services provided under their crippled children's program." Yet on the next page GAO reports that "Pennsylvania...now limits funding for patients with cystic fibrosis to five days of hospital care rather than unlimited hospitalization." This might not be an outright dropping of services, but it certainly is difficult to explain this distinction to parents of a child suffering with cystic fibrosis.

Second, GAO investigators left unresearched and unanswered many crucial assertions by state officials, particularly those relating to the alleged availability of equivalent services for mothers and children previously served by Title V-funded providers. Cutbacks occurred simultaneously in every federally assisted program. Thus, the mere fact that a defunded MIC project might be located within the same catchment area as a Community Health Center would be irrelevant if the CHC was no longer in fact able to provide an adequate level of services to its own patient population. For example, in Maryland, serious MCH cutbacks in 1982 occurred simultaneously with Community Health Center cutbacks that led to a 31,000 person reduction in the number of patients served.

Since GAO did not inventory other sources of care in the communities visited in order to determine whether services of equal scope and quality were still accessible, it is impossible to accept the report's implication that key services remained generally available, despite MCH reductions (especially since the report was not set in any context and did not attempt to measure existing community need). Moreover, these assertions lie in stark and ironic contrast to some of the cases reported in the study. For example, the Iowa MIC officials interviewed by GAO (page 38) admitted that since they do not keep track of clients no longer served, they did not know if women were able to locate alternative sources of care.

In conclusion, the GAO study paints a vivid picture of the dilemma facing many MCH officials who are acutely aware of the need but are unable to respond. It is imperative that MCH Block Grant funding be increased so that we are no longer confronted with having to choose between types of children or categories of illnesses. More importantly, however, it is evident that this block grant program alone cannot possibly begin to cope with the amount of unmet need. The MCH Block Grant is a planning, resource development and "gap filler" program. It is not designed to function as a source of comprehensive health insurance for 15 million uninsured children and millions of poor and uninsured women of childbearing age. The program cannot begin to deal with the need for hospital care, for example. The Block Grant must be coupled with major reforms in Medicaid. Congress must begin these reforms by immediately enacting the Child Health Assurance Act and AFDC/Medicaid reforms now being considered by the House and Senate Budget Reconciliation Conferees.

STATEMENT OF R. DON BLIM, M.D., ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS, WASHINGTON, DC

Dr. **Blim**. Mr. Chairman, I am Dr. Don Blim, a pediatrician in private practice from Kansas City. I am here today representing the American Academy of Pediatrics.

I take particular pleasure in appearing today, for it was just over 3 years ago that I testified before this committee in support of the establishment of the maternal and child health block grant.

I commend you, Senator Durenberger, and Senator Dole who is my Senator, on your leadership in establishing this block grant for mothers and children.

The academy is in general in agreement with the General Accounting Office's report as a fair assessment on how States administered this block grant during the brief 2 years it covers. State administrators should be commended for their ingenuity in protecting these programs through a variety of cost shifting mechanisms in an attempt to integrate these programs into the overall State health budget process. This, however, is not the time to pat ourselves on the back for a job well done; our job is really just beginning.

It should be pointed out that two major factors greatly facilitated the States' ability to adjust to the block grant format:

First, the forward funding, which was in the system when this change was initiated; and, second, the fact that this committee, to its credit, instituted and insisted that each State maintain a distinct administrative unit to implement the program.

The academy would suggest that this committee request that GAO conduct a regular periodic assessment of the impact of this block grant. Perhaps a report every 2 years would provide the guidance to assist the committee in periodic adjustments to the program.

With that in mind, I would like to take this opportunity to focus not on what we have accomplished, but rather to address our unfinished business with respect to the maternal and child health block grant.

My comments will focus on four major areas:

First, the administrative structure of maternal and child health programs within the Department; second, funding issues; third, priorities for set-aside moneys; and, fourth, the need for a common data base. It is these four key elements that are significant barriers to both the Federal and State bureaucracies in making a commitment to our children's health.

First, the Office of Maternal and Child Health. Public Law 97-35 called for an administrative unit for maternal and child health services within the Department to coordinate a variety of child health programs and provide technical assistance to the States, among other responsibilities. Nothing has happened.

The United States is shamefully one of the few industrialized nations which does not have a high-level policy unit for children's health within its governmental structure. Instead, we have buried our office on Maternal and Child Health at a low level within the Department, and we have given it little authority or asked for accountability or new direction. We have no focal point of our Federal efforts to promote child health and well-being, or even a sound Federal policy in this regard.

Child health cannot be viewed in a vacuum. Congress must review in detail its myriad of patchwork programs constituting child health policy to determine their efficiencies and effectiveness.

It is apparent that American children today do not have the same problems as children 25 years ago, because they are not the same kinds of children. Congress must develop public policy and strategies to address the children of the eighties. The philosophy behind the maternal and child health block grant was to reduce fragmentation and coalesce all health programs for children. The administration has not complied with this intent and continues to present to the States a disjointed and uncoordinated health effort for our children.

Senator **Durenberger**. How can you say that? I've got a book here that says we have been gathering information for years and years and years on, a wide variety of stuff, and we have committed 10 to 15 percent of the block grant to channel all of this knowledge into the Division of Maternal and Child Health.

Dr. **Blim**. Well, we are calling attention to the need for a special office.

So, to summarize the health needs of the maternal and child health population, it cannot be simply met by a series of disease- or income-directed projects; the health of mothers and children cannot be equated simply with being ill, with being hospitalized, with being handicapped, or even with being poor. Health care for America's children ranges from superb to nonexistent. The problem is that many of America's children have no access to primary health care; many of the others use the health care system only sporadically, which is expensive, rather than being integrated into a system of continuous preventive and therapeutic care. Many mothers give birth having received little or no prenatal care. It is primarily these unserved mothers and children who account for the fact that 15 other countries have a lower infant mortality rate. That wide discrepancy exists between races, socioeconomic groups, in indicators of health status that children still die from disease, totally preventable, and that many adults suffer needlessly from handicapping conditions acquired during infancy.

If this deplorable situation is to change, it will require Federal leadership to help this Nation's mothers and children.

A new administrative unit at a high level within the Department cannot do it alone; we must have the necessary research tools, specific data on child health status, and a secure fiscal policy to even begin to develop a comprehensive child health policy.

On MCH funding—if the Federal budget serves to reflect the priorities of this nation, mothers and children rank reprehensibly low. The maternal and child health block grant is but one example. Even though the studies show that in most States the same services are being provided, many people in need of maternal and child health services will not receive them. States are also experiencing an increased demand for services under the maternal and child health block grant. This derives from a decrease in medicaid funding and services and from loss of private health insurance due to unemployment.

The academy calls the committee's attention to the immense and urgent gap represented by the near poor or those not supported by medicaid. The infusion of the jobs bill funds to supplement the maternal and child health block grant was an extension of the Congress' intent for these programs. Those funds are now spent, with no funds to replace them. This leaves the administrators of maternal and child health programs in the untenable position of attempting to support personal health services for the near-poor from an annual appropriation never intended to fill such a void.

The estimate of children living in circumstances which would characterize them as working-poor families is approximately 9 million. If the entire appropriation was spent on just this segment of children, it would only average $44 per child per year. It is inappropriate to give anyone the illusion of having such a responsibility when funding is below subminimal need.

In our opinion, the full impact of the budget cuts have yet to be experienced. Reduced dollars coupled with fluctuating spending patterns lend no stability to program administration or development.

We anticipate program changes in many States. Our preliminary information and the GAO report seem to indicate that States will favor broadly targeted programs and those historically receiving State funds. Tragically, recent reports have been made of increased infant mortality in some States, indicating areas of compromised service.

Furthermore, if one projects from California's experience with proposition 13, reductions in prenatal care, family planning, well-child care, and immunization programs can be anticipated, as well as the associated morbidity that comes with such reductions. At a minimum, a realistic appropriation level should be set with inflation factors adopted for each subsequent year.

The set-aside funding: The report does raise some concern over the relatively low priority that States have assigned to programs funded under the set-aside money. The academy has no particular wisdom to offer the committee on the problems some States seem to be having in this regard.

We are supportive of the 15-percent set-aside provision in the block grant and urge that it be maintained.

The data base: It is difficult to assess the complete impact of the funding cuts on people and services, because existing baseline data are poor. You cannot risk simply being told that it is not known what was accomplished by the appropriation because the funds are used differently in each State. You cannot meet your responsibilities to adjust these programs in place, if the accomplishments and deficiencies resulting from block grants are not provided.

The purpose of such reporting would not be to merely satisfy a Federal requirement, but would be to stimulate the development of a working document that could be used to allocate funds and to measure progress at the State level. Appropriate Federal reporting requirements must be reinstituted to allow us to track key health indicators so that as a nation we can determine the health status of our children, our progress and our problems.

Thank you, Mr. Chairman. The academy would be willing to continue to cooperate and help.

[The prepared statement of Dr. R. Don Blim follows:]

STATEMENT OF R. DON BLIM, M.D., F.A.A.P.

Mr. Chairman, members of the Committee, I am Don Blim, M.D., a pediatrician in private practice from Kansas City, Missouri, here today representing the American Academy of Pediatrics. I take particular pleasure in appearing today for it was just over three years ago that I testified before this Committee in support of the establishment of the maternal and child health block grant. I commend you, Senator Durenberger and Senator Dole for your leadership in establishing this block grant for mothers and children.

The Academy is in general in agreement with the General Accounting Office's (GAO) report on the "Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration" as a fair assessment of how states administered this block grant during the brief two plus years it covers. State administrators should be commended for their ingenuity in protecting these programs by a variety of cost shifting mechanisms and an attempt to integrate these programs into the overall state health budget process. This, however, is not the time to pat ourselves on the back for a job well done. Our job is just beginning.

It should be pointed out that two major factors greatly facilitated the states' abilities to adjust to the block grant format: the forward funding which was in the system when this change was initiated and the fact that this Committee, to its credit, insisted that each state maintain a distinct administrative unit to implement the program. The Academy would suggest that this Committee request that GAO conduct a regular, periodic assesssment of the impact of this block grant. Perhaps a report every two years would provide the guidance to assist the Committee in adjustment of the program current to need.

With that in mind, I would like to take this opportunity to focus not on what we have accomplished, but rather address our unfinished business with respect to the maternal and child health block grant. My comments will focus on four major areas: 1) the administrative structure of maternal and child health programs within DHHS; 2) funding issues; 3) priorities for set-aside monies; and 4) the need for a common data base. It is these four key elements that are significant barriers to both the federal and state bureaucracies in making a commitment to our children's health.

OFFICE OF MATERNAL AND CHILD HEALTH

Public Law 97-35 called for an administrative unit for maternal and child health services within DHHS to coordinate a variety of child health programs and provide technical assistance to the states, among other responsibilities. Nothing has happened. The United States is shamefully one of the few industrialized nations which does not have a high level policy unit for children's health within its governmental structure. Instead, we have buried our office of maternal and child health at a low level within DHHS and have given it little authority or asked for accountability or new directions. We have no focal point of our federal efforts to promote child health and well-being or even a sound federal policy in this regard.

Child health cannot be viewed in a vacuum. Congress must review in detail its myriad of patchwork programs constituting child health policy to determine their efficiency and effectiveness. It is apparent that American children today do not have the same problems as children 15 or 20 years ago, because they are not the same kind of children. Congress must develop public policy and strategy to address the children of the 1980s. At a minimum, we need answers to the following questions: What are the goals and objectives of the various child health programs? Are they meeting these objectives? What are the gaps? Where is the overlap? Are these services appropriately integrated, or do they serve to further fragment child health care? At what expense are states undertaking cost shifting to make up budget deficits? How about standards of care? Access to care? The philosophy behind the maternal and child health block grant was to reduce fragmentation and coalesce all health programs for children. The Administration has not complied with this intent and continues to present to the states a disjointed and uncoordinated health effort for children.

To summarize, the health needs of a maternal and child population cannot be met simply by a series of disease or income-directed projects. The health of mothers and children cannot be equated simply with being ill, with being hospitalized, with being handicapped or even with being poor. Maternal and child health services involve setting of standards, development and deployment of resources, demonstrations of new and improved arrangements for assessment of care, and delineation of resources required in terms of facilities, personnel and financing.

Health care for America's children ranges from supurb to nonexistent. The problem is that many of America's children have no access to primary health care. Many others use the health care system only sporadically, rather than being integrated into a system of continuous preventive and therapeutic care. Many mothers give birth having received little or no prenatal care. It is primarily these unserved mothers and children who account for the facts that 15 other countries have lower infant mortality rates than the United States; that wide discrepancies exist between races and socioeconomic groups in indicators of health status; that children still die from diseases totally preventable by immunization and proper health care; and that many adults suffer needlessly from handicapping conditions acquired during infancy or childhood as a consequence of lack of appropriate health care. If this deplorable situation is to change, it will require federal leadership and a commitment to this nation's mothers and children.

A "new" administrative unit at a high level within DHHS cannot do it alone. We also must have the necessary research tools, specifically data on child health status, and a secure fiscal position to even begin to develop a comprehensive child health policy.

MCH FUNDING

If the federal budget serves to reflect the priorities of this nation, mothers and children rank reprehensibly. The maternal and child health block grant is but one example. Even though the studies show that in most states the same services are being provided, many people in need of maternal and child health services will not receive them. Forty-seven states have reported cutbacks either in services, eligibility, or both. Also some states have imposed fees. States are also experiencing an increased demand for services under the maternal and child health block grant. This derives from a decrease in Medicaid funding and services and from loss of private health insurance due to unemployment. Maternal and child health directors report seeing more referrals for the "near" poor, as much as a sixfold increase in some areas.

The Academy calls the Committee's attention to the immense and urgent gap represented by the near poor or those not supported by Medicaid. The infusion of the jobs bill funds to supplement the maternal and child health block grant was an extension of the Congress' intent for these programs. Those funds are now spent with no funds to replace them. This leaves the Administrators of maternal and child health programs in the untenable position of attempting to support personal health services for the near poor from an annual appropriation never intended to fulfill such a void. The estimate of children living in circumstances which would characterize them as working poor families is approximately nine million. If the entire appropriation was spent on just this segment of children, it would only average $44 per child per year. It is inappropriate to give anyone the illusion of having such a responsibility when funding is so woefully below some minimal need.

In our opinion, the full impact of the budget cuts has yet to be experienced. Reduced dollars, coupled with fluctuating spending patterns, lend no stability to program administration or development.

We anticipate program changes in many states. Our preliminary information and the GAO report seem to indicate that states will favor broadly targeted programs and those historically receiving state funds. It appears that Crippled Children's services will receive a large share of maternal and child health funds because it is an older, statewide program with a vocal constituency. In fact, most states list services for crippled children as a top priority. It appears that other programs focusing on sudden infant death syndrome, genetics, hemophilia and lead-paint poisoning, or programs designed to meet needs of the inner-city poor may not fare as well. The states focus on serving those with the greatest need; thus the impact of reduced services will most likely fall on the recently unemployed, the working poor or the moderately handicapped. Tragically, recent reports have been made of increased infant mortality in some states indicating areas of compromised services. Furthermore, if one projects from California's experience with Proposition 13, reductions in prenatal care, family planning, well-child care and immunization programs can be anticipated as well as the associated morbidity that comes with such reductions.

At a minimum, a realistic appropriation level should be set with inflation factors adopted for each subsequent year.

SET-ASIDE FUNDING AUTHORITY

The report does raise some concern over the relatively low priority states have assigned to programs funded under the set aside monies. The Academy has no particular wisdom to offer the Committee on the problems some states seem to be having in this regard. We are most supportive of the 15 percent set aside provision in the block grant and urge that it be maintained. These monies are directed at problems extending across states, support resources being developed to serve health needs of children across the country and enable the development of new or alternative approaches to providing needed health services for children. This set aside authority is a critical element in our national programs for children. However, we would urge this Committee to pay specific attention to how priorities are assigned under this so-called discretionary authority. The logical starting point is to establish National priorities. We would recommend that there be proposed rulemaking on the important issue of selecting priorities for the allocation of these funds. The proposed priorities should be published so that the public and the Congress could examine and comment on them before their adoption. In addition, an appropriately representative group to advise the Secretary or her designate on the priorities for allocating these funds should be established. The sum of monies involved are too great to condone the decision on priorities and review mechanisms to be left completely in the hands of government staff.

DATA BASE FOR BLOCK GRANTS TO STATES

It is difficult to assess the complete impact of the funding cuts on people and services because existing baseline data are poor, and future data will not be comparable due to changes in the reporting system.

In the conversion to the block grant system, specific reporting requirements have become too relaxed. It is not enough to monitor the process by which federal funds are passed to the states; one must also monitor the effect associated with the use of such funds. You cannot risk simply being told that it is not known what was accomplished by the appropriation because the funds are used differently in each state. You cannot meet your responsibilities to adjust those programs you set in place if the accomplishments and deficiencies resulting from block grants are not provided. The Administration must be required to identify before the fact its plan for assembling appropriate data relative to the effect of the block grant authorized.

You must insist that you receive information on the services provided to women surrounding reproductive health, including antepartum, intrapartum, postpartum and family planning services. Similarly, you should require adequate information on those women in need of such services who were not able to be served through the block grant approach. You should insist that sufficient details be presented to identify the circumstances which prevent these women from receiving needed health services and what is proposed to meet such need. The same detailed information should be required for infants, children and adolescents regarding health services provided and where such services could not be provided.

The purpose of such reporting by states would not be to merely statisfy a federal requirement, but would be to stimulate the development of a working document that could be used to allocate funds and measure progress at the state level. Appropriate federal reporting requirements must be reinstated to allow us to track key health indicators so that as a Nation we can deterine the health status of our children, our progress and our problems.

Mr. Chairman, we can no longer afford as a Nation to ignore our children. As you well know, the investment in one generation is an investment in the next. By ignoring this challenge, we are indeed ignoring our future. The Academy stands ready to assist you and the Committee in this process.

Senator **Durenberger**. Thank you very much.

Dr. Nelson?

STATEMENT OF RICHARD NELSON, M.D., ASSISTANT PROFESSOR, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF MINNESOTA AND MEDICAL CONSULTANT, CRIPPLED CHILDREN'S PROGRAM, MINNESOTA DEPARTMENT OF HEALTH, MINNEAPOLIS, MN

Dr. **Nelson**. Let me just restrict my testimony to a couple of comments.

In response to an earlier question that you directed to Senator Bumpers, I think that many of us look at title V as a source of national leadership for the health care of mothers and children. Certainly, title XIX represents the major source of dollars for care, but title V is the only existing Federal commitment to the health of all mothers and children. And I think that Federal-State partnership—really, the title V is the template upon which States build, their programs, not just in dollars but in the concept of trying to provide the services to mothers and children.

In the State of Minnesota during the current fiscal year, the maternal and child health block grant will be significantly reduced from about $7.75 million to $6.2. This is because the dollars available under the emergency jobs bill will be expended during the year. And this is going to place increasing pressure on policymakers in our State to try to prioritize the use of funds.

Sara Rosenbaum has actually given some very good examples in Minnesota of some of the issue raised with decreased medicaid eligibility, and that places additional strains on title V to try to meet some of the needs of low-income mothers and children seeking care. Clearly the dollars aren't there in our State and I think in all States to pick up the slack in medical assistance benefits.

Since the initiation of the block grant, the Minnesota legislature has not really appropriated any dollars to compensate for the loss of Federal funds. So, while I believe that certainly the statistics reported in the GAO report are accurate and that some States did in fact do that, it is a very uneven process. We in fact have a State where, for preventive health services, Minnesota relies almost exclusively on the Federal dollars in order to mount programs.

In three areas—very briefly—I have great concern. Our State at this time I think is in a continuous political dialog—to be kind—about how to prioritize the money: Conflicts between urban areas and rural areas, conflicts between how to spend money at various levels of government. We are gnawing at a very small bone, and we get into a situation where raw power politics makes decisions about allocations of maternal and child health funds which really denies needy mothers and children resources when their political advocates aren't as strong as others.

Our handicapped children are in a situation where the escalation of health care costs which these children consume, by virtue of their birth defects and chronic disease, really are placing tremendous strains on the program. We found in some situations that costs have gone up 50 to 100 percent in 2 or 3 years in providing care for cleft palate and club foot and others, and the program doesn't have those resources.

These aren't just consuming dollars to provide care; these are what we call secondary prevention. If you don't adequately deal with the primary problems of birth defects, these children are going to require services over their lifetimes that consume many more dollars.

I have one parting observation: I think it is time to look at title V in a new way and to link title V and title XIX. Title V provides a perspective and planning and evaluation and coordination of services. Title XIX is a major reimbursement program. I think if the health status of mothers and children, especially low-income mothers and children, is going to significantly improve, we can't have these two Federal programs marching along in parallel, in most situations. There is data that when title V and title XIX are linked at the State level, we get a much more efficient and comprehensive use of dollars. And I think that is the challenge in looking at the block grant.

Thank you.

[Dr. Nelson's written prepared statement follows:]

STATEMENT OF RICHARD P. NELSON, M.D., UNIVERSITY OF MINNESOTA, GILLETTE CHILDREN 'S HOSPITAL, ST. PAUL, MN

I am Dr. Richard P. Nelson, Assistant Professor of Pediatrics at the University of Minnesota and Director of the Developmental Disabilities Program at Gillette Children's Hospital, St. Paul.

This testimony will focus on the efforts of MCH block grant programs to improve the health of mothers and children, including children with chronic illness or disability. In all states these programs continue to function after the block grant but a struggle with inadequate resources. As a former director of the Title V Minnesota Crippled Children's Program, my primary focus will be services for children with chronic illnesses or disabilities.

Legislative Mandate Under the Block Grant

The legislation creating the Maternal and Child Health Services Block Grant in 1981 specified four purposes for the amended Title V of the Social Security Act. The purposes are as follows:

1. To assure mothers and children (in particular those with low income or with limited availability health services) access to quality maternal and child health services.

2. To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children... and to promote the health of mothers and children.

3. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (Supplemental Security Income).

4. To provide services for locating, and for medical, surgical, corrective, and other services, ... for children who are crippled or who are suffering from conditions leading to crippling.

These objectives provide the compelling frame work for state maternal and child health programs. The agenda for these programs is nothing less than a continued improvement of the health of child-bearing and rearing women and their children. The programs function in a context of a complex health care industry including diverse practitioners, facilities, and public and voluntary programs.

Program Mission Under the Block Grant

The maternal and child health block grant programs are public health programs and their mission has been and is to promote the development of the system of health care for all mothers and children. This mission involves the performance of a variety of functions including planning, coordination of services, standard setting, the introduction of innovative methods of health care in to the service delivery system, training and education, and the provision of direct service and outreach.

Considerable effort and resources are deployed to provide health care services and related services to mothers and children through the Title V maternal and child health block grant program. In states with limited Medicaid eligibility and large low-income populations, the Title V state maternal and child health programs are generally the only source of direct services for mothers and children who do not have adequate insurance or personal financial resources to obtain needed health care. Moreover, there are localities within states where private health providers are simply unavailable, and there are communities and within states when private health providers are unable or unwilling to furnish care to Medicaid eligible women and children. Hence, the state maternal and child health programs have developed maternity and child health clinics which provide prenatal care, newborn care, and well child care including immunizations, developmental assessments and vision and hearing screening.

The FY 1984 MCH block grant budget significantly decreased to slightly more than $6.2 million. State policymakers face difficult short-term decisions concerning the use of reduced MCH block grant funds. To a great extent, the Emergency Jobs Bill appropriations temporarily delayed decisions that the Commissioner of the Department of Health must now make. Recognizing the problem of increased state discretion over a reduced budget, the 1982 Minnesota Legislature passed an act which established an MCH Advisory Task Force to facilitate a planning process, and provide recommendations to the Commissioner of Health on the award, distribution, and administration of MCH block grant funds after July 1, 1983.

The MCH Advisory Task Force made an initial set of recommendations prior to their knowledge of the availability of additional funds via the Emergency Jobs Bill. They did not recommend an across the board or pro rata reduction of MCH funds. Rather, they recommended redistributing funds with special emphasis on identifying and targeting resources to those populations with the greatest risk for poor health status.

The Medicaid program in Minnesota is one of the most comprehensive programs in the country. It provides the complete range of services made optional by the federal government, and provides coverage for two-parent families whose principal wage earner is unemployed and for women who are pregnant for the first time. In 1982, the income standard for a family of four in

Minnesota that was used to determine eligibility for Medicaid was the fifth highest in the nation, albeit still well below the federal poverty level. In FY 1982, 48 percent of Minnesota Medicaid beneficiaries were children accounting for 11 percent of Medicaid expenditures and resulting in an average expenditure of $530 per child. This figure is slightly higher than the national average Medicaid expenditure of less than $500 per child in 1982.

One major impact of the federal cutbacks in Minnesota has been the loss of Medicaid eligibility for more than 13,500 households during the past two years directly due to the substantial changes initiated in the AFDC program by the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Hoffman, 1984). The primary effect of these changes has been the termination of welfare assistance, and hence Medicaid coverage, for the majority of working AFDC recipients.

During fiscal year 1981, the last year preceeding the MCH Services Block Grant, the Crippled Children's Services programs provided services to 605,582 children. A large majority of these children, almost 570,000, receive their services through cost effective ambulatory care. For children requiring more intensive surgical or medical treatment, inpatient services were provided to 94,851 children, involving over 711,000 patient days of care.

In addition, several of the programs consolidated in the maternal and child health block grant programs in 1981 aredirect service programs. These programs include the Sudden Infant Death Program, the Lead Poisoning Program, the Hemophilia Program and the Genetics Program.

Impact of Federal Funding Cuts

The Omnibus Budget Reconciliation Act of 1981, the parent legislation for Maternal and Child Health Services Block Grant, generally reduced the overall allocation of federal dollars to the states by approximately 18%. This reduction occurred at a time when many states were experiencing severe difficulties in their own budgets. In Minnesota no additional state funds were appropriated to compensate for the loss of federal funds. Further specific constraints were placed on maternal and child health activities due to inflation of costs in the health care sector which at that time continued at double-digit rates.

The funding reductions created a milieu of uncertainty in many states. State health commissioners and other decision makers wondered about the longevity of maternal and child health grants and this discouraged further program development or innovation.

The creation of the block grant funding mechanism also suggested to some providers and agencies that "new money" had suddenly been provided to states for new activities not previously funded under Title V.

Out of this environment of uncertainty several trends have emerged. I would like to provide several examples from this State of Minnesota which illustrate the impact of funding, and indicate why current funding of Title V is not adequate.

1. Decreased eligibility for perinatal and child health programs.

   Following reduction of funds to support maternal and child health programs administered by the Minneapolis Health Department, eligibility was reduced which excluded hundreds of low-income women from services that had been available for decades. Despite the prior demonstration of the effectiveness of these programs to diminish the frequency of low birth weight in their target areas. The potential for the health department to serve this needy population was compromised. Many women, including those from ethnic minorities, were not able to obtain recommended prenatal care without utilizing their very limited discretionary income. Child health services beyond infancy have been even more restricted due to high priority of decreasing infant mortality and morbidity.

In St. Paul the successful efforts to reach adolescent pregnant young women through high school clinics were also limited due to decreased funding.

Funds be restored to pre-block grant levels, at a minimum, to reinstitute the services available for this target population.

2. Reduced eligibility for children with chronic illness and handicaps.

The Minnesota Crippled Children Services Agency (Services for Children with Handicaps) was not able to adjust its financial eligibility scale from 1977, until early this year. Despite an increase in median family income in the state during that time, the purchasing power for low-income families has not improved. Financial eligibility in absolute income dollars was unchanged. Therefore families were unable to qualify for services through the program.

In 1983 there was a reduction of 27% in the number of families re-applying for services as compared to 1981 (3,650 re-applications in contrast to 4,992 applications), which does not indicate less need for program services, but the recognition by families that they no longer qualified due to slight gains in their personal income.

Similarly during this period the program was able to authorize for 30% fewer episodes of health care (6,461 versus 9,203) due to increased costs. For example the average annual cost of care for a child with cleft lip and palate paid by crippled children's funds rose to $1598 from $1006 the previous year. Static program resources could not absorb these increases without restricting services.

Funding should be brought to pre-block grant levels so that population of families historically served by these programs can obtain necessary services.

3. Limitation in scope of services

Many clinics and professional services provided by Crippled Children Services Agencies have been limited since the introduction of the block grant. With the uncertain funding milieu staff positions in Minnesota have not been filled for prolonged periods, new needs have not been addressed, and in some areas the comprehensiveness of care has been decreased. In Minnesota the number of visits to program outreach clinics throughout the state has declined from approximately 7,500 to 6,000 annually during the past two years secondary to a reduction in the number of clinic sites that could be funded with available program dollars.

It is essential to restore services to low-income mothers and children. Funding levels, as permitted by authorization under Title V, should be increased. Constant service funding for Title V, projecting the purchasing power of fiscal year 1980 dollars to 1984 dollars, would require an appropriation of about $600 million.

The urgency of maintaining effort on behalf of mothers and children cannot be overstated. We have lost capability during the past three years, but still have the opportunity, with the maternal and child health services structure in place, to restore necessary services.

Senator **Durenberger**. Thank you very much.

Let me just ask one question of this panel, because we are running a little late. I would ask Sara and Dr. Blim to react to this last part, because this is the sort of objective that has been going through my head.

If you adopt Dr. Graham's thesis that in addition to just plain caring about people—which unfortunately he didn't add into his thesis, but I know he means it, and you all have—add the thesis that because we at the Federal level are financing 40 percent of the sick care system in this country today we ought to have a strong interest in prevention. Is Dr. Nelson correct in suggesting to us that trying to define this Federal partnership and trying to pull in the efficiencies of State and local administration of programs and the efficiencies of a national funding system of some kind, that we might view title V primarily as a detection-prevention kind of a program which would be required in all States in order to get at the larger moneys for the economically disadvantaged in title XIX or in some of the other titles that deal with crippled children and the blind and so forth, since this is where it all starts?

I mean, it starts with pregnancy, and it starts with birth. And all of the rest of these titles and the Social Security Act follow therefrom.

I just want to say that one of the reasons we are looking at the economically disadvantaged is that title XIX creates problems for us because it defines a certain subset of economically disadvantaged, and it ties it in with a whole other program that is in this committee called "Aid for Dependent Children." And as we do that, we just gradually narrow the access for a whole lot of people to the system.

Maybe I could just get a quick reaction from both of you in terms of where this subcommittee might devote a little bit of attention, because it has been suggested we do. I mean, despite what Dale said, you folks are it, and you are here time after time after time. I would ask you to continue that commitment.

Could I start with you, Sara?

Ms. ROSENBAUM. I not only agree with Dr. Nelson, but in the time that we don't spend talking to folks in Congress we do a lot of technical assistance with the States. One of the issues I spend most of my time working on, in fact, is trying to develop stronger linkages between title V and title XIX. There is a lot of discretion right now in both acts. Because so many children are uninsured so much of the time that, unless the two programs work closely in tandem and think about the most creative ways to use title XIX dollars to shore up an entire public system, many, many children are going to fall through the cracks.

I would say that life would be a lot easier if title XIX were to set minimum equitable requirements regarding coverage for children.

You know, there is no other group under title XIX for whom categorically discriminatory requirements are used. For instance, if you are over 65 you don't have to be married or unmarried or have a grandchild or not have a grandchild; you are simply eligible if you are poor. We are not at that place yet with title XIX with respect to children. And while we can do some creative gerrymandering of titles V and XIX to make them work better together, I'm sure Dr. Nelson keeps coming up against this problem of having a huge pool of children who fall through the cracks.

Now, title XIX, despite being a highly discretionary program, has many, many minimum requirements. So in that sense it is not groundbreaking to suggest that there be a minimum requirement that, in return for spending $25 billion a year of Federal money on the program, States cover pregnant women and children for basic services.

In addition, the two programs certainly can be brought more closely together.

Senator DURENBERGER. Well, the thing in your suggestion that will just drive some people crazy, the so-called efficiency experts, is if you would even dare to suggest that everyone under 10, for example, or pick an age, should qualify for a program. They would say, "You are out of your tree," because pretty soon it would be $2 billion, $4 billion, $6 billion, et cetera.

And yet at the some time we are advocating, for example, tuition tax credits for elementary and secondary education.

Ms. ROSENBAUM. The cost is so minimal compared to the payoff of giving people access to health care. Right now it is estimated that retardation rates, with adequate prenatal care among women who don't get it, could be cut in half. That is one study's estimate. Now, the cost of retardation is so drastic in this country that you could finance that addition to medicaid and cut medicaid ICFMR payments, where a lot of children who are chronically retarded are living.

So it is a matter of where you are going to invest, not where you are going to throw money. The money is being spent now, as you pointed out.

Senator DURENBERGER. Dr. Blim.

Dr. **Blim**. I would certainly support Dr. Nelson's suggestion. I think we have a lot of answers, but maybe we haven't asked all of the questions.

We really don't have any central office or focal point for these questions. This is why we are in support of that.

Senator **Durenberger**. Well, thank you all very much. I appreciate your commitments, your statements, and your willingness to be here today.

The next panel consists of Mr. Eugene Durman, senior research associate at the Urban Institute; Ms. Sandra Anderson, director of intergovernmental affairs for the Health Services Department of Los Angeles County, CA; and Dr. John MacQueen, Codirector of the National Maternal and Child Health Resource Center, Iowa City, IA, on behalf of the Association of Maternal and Child Health and Crippled Children's Programs.

I welcome all three of you. You probably didn't notice that we haven't been using the lights here, but we are going to use the lights, since the time marches on, and I'm sure you all have airplanes to catch—at least, two of you do.

We will start with Mr. Durman.

STATEMENT OF EUGENE DURMAN, SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, DC

Mr. **Durman**. Thank you, Senator.

I would like to report primarily on an Urban Institute study of the implementation of the MCH block grant. We are now entering the third year of the study. We have been examining implementation in 18 States. We have coordinated our efforts with the General Accounting Office. There is some overlap in the States, but between the two studies we have at least some look at some 22 States around the country. So between the two studies we have a fairly comprehensive look at what has been going on.

I will offer a brief summary of the results of the study. By and large they confirm what has been reported by GAO. I would be very willing to take any additional questions concerning the study or some of the broader questions that have been raised here today.

States have remained financially committed to MCH services. Of the 13 States for which we have complete financial data, 10 made at least some attempt to replace lost Federal dollars in nominal terms. In real dollars, however, the States generally have not been as successful in fully replacing lost Federal dollars; only four States have succeeded in full replacement, if one assumes an inflation rate of just over 7 percent per year. I would point out that some estimates of inflation in these services would be higher than that.

While States have remained financially committed to MCH services, the priorities that they have assigned to specific services differ somewhat from those expressed under the prior categorical programs. States were consistent, though certainly not unanimous, in favoring the general broad-based MCH and crippled children's services over the more narrowly targeted programs such as lead-based paint, SIDS, and adolescent pregnancy.

States were also consistent within the previous title V MCH services in favoring the general services over the previously federally mandated program of projects.

A number of States also shared the tendency to combine the SSI Disabled Children's Program into the more general crippled children's services.

In addition to these programmatic changes, the MCH block has apparently encouraged at least two sorts of changes in the relationship between States and localities. This is one of the major intergovernmental issues that was raised in the discussions surrounding the creation of the block grants.

A number of States have developed funding formulas which achieve some shift in funds from localities that had previously received relatively large shares into localities that had previously received a somewhat smaller share of the funds. These formulas were almost always based on a definition of need within the State; they were not arbitrary, simply based on the State's population, but did have a substantial component of need derived in various means in the various States.

In addition to this trend, a number of States have passed to local governments the authority to allocate MCH funds, creating in effect their own block grants to localities out of the Federal block grant to the States. In some instances this represents a continuation of the existing relationship between the States and localities, and in some instances it represents a new development with some greater authority being passed to the local governments.

Finally, several States either have completed or are contemplating administrative changes as the result of the MCH block grant. As GAO has indicated, States are generally pleased with the elimination or simplification of the Federal requirements.

No State that we talked to, however, would claim significant dollars savings as the result of the MCH block grant. There were administrative changes; they were able to use their staff differently. These changes did not translate into large dollar savings.

Senator DURENBERGER. Thank you very much.

Ms. Anderson?

[Mr. Durman's written prepared statement follows:]

Testimony before the Senate Finance Committee,
Subcommittee on Health, concerning the MCH Block Grant
June 18, 1984
Gene Durman, The Urban Institute

The MCH Block Grant, created by PL 97-35 (the Omnibus Budget Reconciliation Act of 1981), combined two large established programs with seven smaller programs generally of more recent origin. The two large programs, Maternal and Child Health Services and Crippled Children's Services distributed the bulk of funds to states by formula and required a federal match. States were not necessarily involved with the smaller programs prior to the creation of the block, but became responsible for allocation of funds to these programs when the block grant took effect. In practice, several of the smaller programs including Genetics Testing and Counseling, Hemophilia Services, and MCH Research and Training were insulated from state discretion by the clause in PL 97-35, reserving 10 to 15 percent of the MCH appropriation for "projects of national significance." Thus, states, in effect, assumed responsibility for Childhood Lead Based Paint Poisoning Services (LBPP), Adolescent Pregenancy Community Programs, Sudden Infant Death Syndrome Projects (SIDS), and SSI Disabled Children funding.

The Urban Institute has studied state level implementation of the MCH and other block grants as part of a three year study supported by both HHS and Ford Foundation funds. Our analysis of the MCH Block Grant focuses on three important questions raised by the creation of that block: 1) the extent of state efforts to replace lost federal dollars, and the nature of the priorities expressed in these efforts, 2) the extent of changes in state-local relations associated with the block, and (3) the nature and extent of administrative efficiencies achieved as a result of the block grant.

1. Fund Reallocations.

Federal Reductions, State Replacement, and Fund Availability. The block grant cut in federal MCH appropriations for FFY 1982 was initially 24 percent before supplemental appropriations. However, block funds were not the only federal aid available to support MCH programs during FFY 1982. Because states did not spend all the federal categorical money in the year it was appropriated, past federal funds overlapped the blocks during the transition between systems of federal aid. These categorical dollars provided 24 percent of federal MCH funds spent by states during SFY 1982. As a result, state MCH spending of federal funds dropped only about 8.7 percent below 1981 levels in SFY 1982, the block's first year. Some states elected to carry forward part of this one-time cushion of overlapping funds by reserving some 1982 block funds for later use, thus absorbing the block cuts more gradually. States could also transfer federal funds from other blocks to MCH. Five of the eighteen--Colorado, New Jersey, Ohio, Oregon, and Vermont--elected to do so, but the transfers represented a small dollar amount when compared to carryover funds used.

By the block's second year, states generally faced the question of whether to replace lost federal MCH dollars. Table 1 suggests that four of the thirteen states for which we received complete fiscal data succeeded in replacing lost federal MCH funding when inflation (as measured by the general increase in the cost of goods and services purchased by state and local governments) is taken into account. One state (Vermont) did not experience a reduction of federal expenditures, but increased state expenditures substantially (67 percent). Two states increased state expenditures above the rate of inflation but did not fully replace lost funds (California, Minnesota). Three states had decreases in state

Table 1

CHANGING FUNDING SOURCES FOR MCH SPENDING
(Millions of Dollars)
State Fiscal Year Basis

	SFY 1981	SFY 1982	SFY 1983	% Change 81-83
Arizona				
State	4.1[b]	4.6[b]	4.5[b]	9.8
Block & Carryover	5.1	4.9	3.3	-35.3
Other Federal	0.0	0.1	0.0	—
Local & Other	0.0	0.0	0.0	0.0
Total	9.2	9.5	7.8	-15.2
California				
State	34.2	38.0	43.5	27.2
Block & Carryover	23.5	20.9	24.2	3.0
Other Federal	0.9	1.1	0.5	-44.4
Local & Other	17.2	18.4	20.5	19.2
Total	75.7	78.3	88.3	17.3
Colorado				
State	4.6	5.2	3.5	-23.9
Block & Carryover	7.6	7.1	6.6	-13.2
Other Federal	1.0	1.0	1.2	20.0
Local & Other	1.7	1.7	2.0	17.6
Total	14.9	15.0	13.3	-10.7
Florida				
State	29.0	33.3	37.5	29.3
Block & Carryover	13.3	11.1	10.4	-21.8
Other Federal	4.5	4.2	4.0	-11.1
Local & Other	7.0	11.2	11.7	67.1
Total	53.8	59.7	63.6	18.2
Illinois				
State	13.6	13.8	12.7	-6.6
Block & Carryover	13.8	14.0	14.0	1.4
Other Federal	0.1	0.0	0.0	-100.0
Local & Other	0.0	0.1	0.0	0.0
Total	27.5	27.9	26.7	-2.9
Kentucky				
State	11.5	12.6	15.0	30.4
Block & Carryover	6.7	7.4	7.0	4.5
Other Federal	3.6	3.5	2.5	-30.6
Local & Other	0.0	0.0	0.0	0.0
Total	21.8	23.4	24.5	12.4
Massachusetts				
State	6.8	6.6	7.5	10.3
Block & Carryover	9.9	10.0	10.1	2.0
Other Federal	0.4	0.4	0.1	-75.0
Local & Other	0.0	0.0	0.0	0.0
Total	17.1	16.9	17.7	3.5
Michigan				
State	14.2	15.6	15.5	9.2
Block & Carryover	13.6	12.5	13.6	0.0
Other Federal	0.7	0.7	0.6	-14.3
Local & Other	5.5	4.7	6.2	12.7
Total	34.0	33.5	35.9	5.6
Minnesota				
State	2.8	3.7	3.5	25.0
Block & Carryover	8.1	7.3	6.1	-24.7
Other Federal	*	0.0	0.0	-100.0
Local & Other	0.1	0.0	0.0	-100.0
Total	11.0	10.9	9.6	-12.7
Missouri				
State	10.8	9.2	8.9	-17.6
Block & Carryover	8.4	8.1	8.0	-4.8
Other Federal	*	0.2	0.2	410.3
Local & Other	0.0	0.0	0.0	0.0
Total	19.2	17.5	17.1	-10.9
New York				
State		22.2	22.2	0.0[c]
Block & Carryover	N/A	30.1	29.8	-1.0[c]
Other Federal	N/A	3.6	3.8	5.6[c]
Local & Other		31.2	32.2	3.2[c]
Total		87.[illegible]	88.1	1.0[c]
Texas[d]				
State	20.9	27.9	38.6	84.7
Block & Carryover	21.7	16.7	18.2	-16.1
Other Federal	0.0	0.0	0.0	—
Local & Other[e]	1.1	3.3	0.7	-36.4
Total	43.7	48.0	57.5	31.6
Vermont				
State	1.8	2.3	3.0	66.7
Block & Carryover	1.1	1.2	1.2	9.1
Other Federal	0.5	0.6	0.6	20.0
Local & Other	0.0	0.0	0.0	0.0
Total	3.4	4.0	4.8	41.2

SOURCE: Data supplied by states.

Note: Totals may not add due to rounding.

a. "Other Federal" includes block-grant-related categorical support. "Local and Other" includes those local funds provided in response to state requirements, and fee and reimbursement revenues of which the states are aware. Reimbursements include those from Title XIX (Medicaid) as well as from private insurers. Fees, reimbursements and general public support raised at the local level for these programs are not reported herein.

b. Does not include funds in support of CCS.

c. One-year change; block not accepted until SFY 1982.

d. Federal fiscal year basis.

e. Does not include local match.

* Less than $0.05 million.

spending even in nominal terms. The remaining three states increased state spending but at a rate less than general inflation.

States had two other means of increasing available funds. First, they could make up for lost federal funds by requiring localities to increase their contribution for joint state-local MCH activities. Second, states could increase fees for service or collections from third-party insurers or government programs (e.g., getting full Medicaid payment for medical care also covered under Crippled Children's Services). Overall, four states (California, Colorado, Florida, and Michigan) indicated significant increases in spending from local and other sources (see Table 1).

Reallocating Funds Across Blocked Programs. Block grants also allow states to shift federal funds away from previously fixed categorical allocations. Major shifts were very rare in the blocks' first year, mainly because states had almost no time to plan for them, funding by congressional continuing resolution created considerable uncertainty, and states were preoccupied by far more pressing fiscal problems--the General Fund revenue shortfalls during recession and far larger federal aid cuts in AFDC and Medicaid. The main state goal in the first year was to maintain the allocative status quo by distributing federal funds pro rata among blocked programs according to their historical share of federal funds.

By the second year, FFY 1983 (mainly in SFY 1983), however, most states were asserting different funding priorities. Our analysis focuses on changes in five programs combined into the MCH Block Grant. These include basic MCH services, Crippled Children's, Sudden Infant Death Syndrome (SIDS), Lead Paint, and Adolescent Pregnancy Health services. Genetic Diseases, Hemophilia, and MCH Research and Training remained almost exclusively funded from the 15 percent federal set-aside. Special

Supplemental Income-Disabled Children (SSI-DC) had too erratic a past funding history to allow over time comparisons.

Interviews with state health staff and the state expenditure data identified CCS and MCH services as top priorities. Though their reasons varied, several officials cited as favorable factors local (county) preferences, positive public testimony, and the programs' long history. However, the "Program of Projects" funded by federal requirement as part of MCH services prior to creation of the block grant was less popular. Typically, state officials cited these programs' lack of statewide coverage as reason for their low priority.

As Table 2 suggests, nine of thirteen states maintained or increased nominal spending (not adjusted for inflation) in MCH, while eight of thirteen did this for Crippled Children's Services. Most of the decline in MCH was a result of reductions in the "Program of Projects" not separately identified. CCS apparently benefited both from its similarities to the relatively new SSI-DC program and the latter's tenuous position in the states' health systems. SSI-DC serves an income-tested sub-group of CCS clients and provides ancillary services that complement the treatment and diagnostic programs provided under CCS. At least eight states merged funding for these two programs, with only a few maintaining full SSI-DC services.

Programs experiencing reduced funding were also fairly consistent across the states. All of the eight states with Lead-Based Paint programs in 1981 reported funding reductions in this category by 1983, three of them completely eliminating funding. Adolescent Pregnancy experienced a significant drop in six states, a modest drop in two states, and an increase in three states. Similarly, SIDS lost funds in eight states while it increased in three others.

Table 2

MCH WINNERS AND LOSERS: SFY 1981-83 CHANGES IN TOTAL SPENDING[a]

	Number of States Reporting					
Programs[b]	Large Rise (>10%)	Small Rise	No Change	Small Drop	Large Drop (>10%)	No Program
WINNERS						
Crippled Children's Services	6	1	1	2	3	0
MCH/Title V[c]	3	5	1	2	2	0
LOSERS						
Lead-Based Paint Poisoning	0	0	0	0	8	5
Sudden Infant Death Syndrome	2	1	0	0	8	2
Adolescent Pregnancy	3	0	0	2	6	2

SOURCE: Compiled from appendix tables A.2 and A.3.

a. Change in nominal dollars from block grant and all related funds, federal, state, and local.

b. No consistent data available on the other categoricals in this block.

c. Includes some MCH research and training, MCH special projects, as well as MCH Services.

This information suggests that states have begun to assert fairly uniform priorities among blocked programs. The geographically limited small-constituency programs such as the MCH Program of Projects, LBPP, Adolescent Pregnancy and SIDS are less favored than MCH services and CCS, statewide health services programs with a long history of federal-state-local collaboration.

Inflation in health care services must be taken into account when assessing the relative gains and losses summarized in Table 2. If we correct spending for inflation in the costs of general state and local purchases, nearly all of the blocked programs experience some loss in real terms.

2. The State-Local Relationship.

In the course of planning for the implementation of the MCH block, states had to face the question of the role of local governments. In most states, officials relied on the established pattern of state-local relations to deal with the block. However, in eight of the eighteen states these issues resulted in a changed distribution of MCH dollars and gave counties a larger role in their disposition.

Three states changed funding distributions to help previously less funded areas (usually non-metropolitan counties) while keeping the former federal categorical programs distinct from each other. Five states went still further, "mini-blocking" at least some portion of the MCH block. Of these, three chose to redistribute at least some MCH dollars so that all counties now received at least minimal funding. These mini-blocks typically gave localities even more autonomy for new federal block funding than they were given previously for spending state funds. The five states developing mini-blocks include:

- -- Oregon formerly awarded MCH services funds on a competitive basis to counties and private non-profit applicants for specific projects. In FFY 1983, the state began distributing MCH block grant funds to counties by a formula that includes need measures as well as a "density" factor to ensure funding even for the least populated areas. Counties are permitted to use the funds for general MCH purposes, and are not restricted as in the past to state-approved projects. As a result of these changes 36 counties now receive MCH dollars, compared with 18 in prior years, and they may use the funds to meet local MCH priorities. Non-county grantees of 1982 were guaranteed a *pro rata* share of funds in 1983, but henceforth must apply to the counties for block grant support.

- -- In 1982, Missouri abandoned its previous purchase-of-service system for MCH services and adopted a new system of general contracts with the counties, which in essence awards local entities new authority over program choices. In addition, Missouri folded former LBPP funds into this MCH services distribution mechanism, ending separate funding for this program. These funds were redistributed by formula to ensure awards to all counties. Interestingly, Missouri plans to return to its original purchase-of-service system (although the LBPP inclusion and redistribution will remain) as a means of insuring provision of needed services.

- -- Illinois has redistributed only "new" funds. MCH supplemental appropriations in FY 1982 were awarded by formula to all counties for disposition at local discretion, within the counfines of MCH-related functions. These funds will be included hereafter in the block for determining *pro rata* distributions; however, Emergency Jobs Bill dollars will not be allocated in this manner.

- -- Ohio has consolidated the pre-block categoricals into two basic MCH programs, and has also altered the existing county distribution formula to favor rural areas more than in the past. Ohio counties thus have broader discretion over redistributed MCH dollars.

- -- New York has awarded an MCH "mini-block" to a private agency providing MCH services for New York City. Though the agency receives a *pro rata* share of blocked MCH funds (no distribution changes have been adopted), it has greater latitude in selecting services offered than previously.

These changes, though in a minority of the study states, suggest an increasing local role in the MCH block that is consistent with states' preference for statewide, basic health services. Should these changes indeed become more widespread, MCH services will become available to some degree in even the least populated counties, but with fewer specialized programs. In most states, this will mean a slight shift in funding distribution from urban to less densely populated areas. In addition, local governments will gain greater control over which services to offer (and by whom), as the increased state flexibility offered by the blocks is passed on to the local level.

3. Administrative Changes.

The MCH block offers states certain limited opportunities to streamline program administration. Elimination of lengthy planning and reporting requirements has enabled at least one of our sample states (Arizona) to reduce or reassign staff, but for the majority the change has simply reduced the "level of aggravation." However, several states, most notably Michigan, New York and Massachusetts, noted that state planning needs have remained constant (if not escalated in the latter state), and that needs assessments, program evaluation and general data collection for block grant decision making require a level of effort at least equal to that under federal pre-block requirements. Thus it is difficult to reach any generalization regarding the administrative and fiscal impact of the federal deregulation.

However, the consolidation of the blocked programs itself offered opportunities for improved administrative efficiency in some states. Ohio, for example, plans to consolidate the MCH programs into two basic grants, one for child and family health services and one for perinatal and infant care, and re-organize the Division of Maternal and Child Health

Services to mirror the simpler and presumably more efficient grant structure. States like Oregon and Missouri, where mini-blocks have been created (see above), note greater efficiency in state administration and suggest significant savings at the local level resulting from the grant consolidation and streamlined application procedures inherent to mini-blocks. Six states merged the SSI-DC and CCS programs, both for ease of reallocation (see earlier discussion) and for improved efficiency. However, while state officials felt this consolidation indeed streamlined administration, they could not provide estimates of savings. Furthermore, this consolidation accompanied by a programmatic change that eliminated many of the distinct services previously available under SSI.

Savings resulting from deregulation and consolidation were thus unusual or hard to document in the MCH block. Because it grouped programs largely already administered by a single division of the state health department, most states found little opportunity for administrative consolidation. Any savings from this block thus appeared primarily from reduced federal reporting requirements, and even these proved uneven across states and difficult to estimate. The sole certainty regarding MCH administrative savings is that in none of the states did these compensate for federal block-related funding reductions.

Summary and Conclusions

The Urban Institute study of the first two years of state implementation of the MCH Block Grant permits several observations:

1. States have remained committed financially to MCH services. Of thirteen states for which complete data are available, ten made at least some attempt to replace lost federal dollars in nominal terms.

In real dollars, however, states have generally not been successful in fully replacing lost federal dollars. Only four states have succeeded in full replacement if one assumes an inflation rate of just over 7 percent per year in these services.

2. While states have remained financially committed to MCH services, the priorities they have assigned to specific services differ somewhat from those expressed under the prior categorical programs. State priorities were consistent (though not unanimous) in: a) favoring general MCH and Crippled Children's Services over Lead Based Paint programs, SIDS services, and Adolscent Pregnancy services, b) favoring statewide programs over the previously federally mandated "Program of Projects" within general MCH services, and c) combining the previously separate SSI Disabled Children's program with general Crippled Children's Services.
3. The MCH Block Grant has encouraged two sorts of changes in the relationship between states and localities: a) a number of states have developed funding formulas which achieve some shift in funds from localities that had previously received a relatively large share of the total dollars, into areas that had previously received a lower percentage to achieve greater geographical equity, and b) a number of states have passed to local governments the authority to allocate MCH funds among specific services by creating what are, in effect, substate block grants.
4. Several states have made or are contemplating administrative changes as a result of the MCH block. While states generally appreciate elimination or simplification of federal.requirements, no state in our study would claim major administrative savings in dollar terms as a result of the block.

STATEMENT OF SANDRA ANDERSON, DIRECTOR, INTERGOVERNMENTAL AFFAIRS, HEALTH SERVICES DEPARTMENT, LOS ANGELES COUNTY, CA, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES, WASHINGTON, DC

Ms. **Anderson**. Thank you.

I am pleased to be able to offer this testimony on behalf of the National Association of Counties, also known as NACO, on the maternal and child health block grants.

In all of the previous testimony that you have heard, when there were references to "service" you have heard a mention of counties. Counties are the essential element of service delivery for maternal and child health. We are purchasers, planners, and financers of health care services, and we have a special role in meeting the needs of the indigent.

For maternal and child health in over 2,000 counties in this country, 89 percent of those counties provide the maternal and child health services, and 48 percent are the only providers of maternal and child health services for low-income and indigent persons.

In Los Angeles County we have a health care budget of $1 billion. That includes our hospitals and our public health care service delivery. One hundred million is spent on maternal and child health, and of that total $66 million comes from our local property tax dollars.

Other counties throughout this country are supporting Maternal and Child Health Programs and are taking care of millions of Americans who have no insurance, are not eligible for medicaid or medicare. In 1981, counties spent $20 billion nationwide on health care coverage.

The maternal and child health block grant consolidated a number of programs, and in California represented a 25-percent reduction in funding. We did not see the same dramatic reduction in programs or services, because there was carryover money that the State had retained, and the jobs bill money that came in 1983 helped us once again to keep from having significant reductions.

But as all of these reserves are depleted, we anticipate that if the appropriation level is not maintained we will have to make drastic reductions in our program.

California receives $18 million annually from the block grant, $4 million of which goes to the crippled children's services, which we call California children's services, and $14 million for maternal and child health. In Los Angeles County we have 7.8 million people, and our numbers of minority persons in the county continues to increase. Presently we anticipate that we have 27.6 percent Hispanics, 12 percent blacks, and 6.5 percent other nonwhites who are primarily Asian-Pacific.

Over 900,000 people, almost a million people, in Los Angeles County are at the poverty level, and this places a tremendous strain on our services in the maternal and child health area. The State funds and our county funds and the Federal funds help us to provide health education, prematurity prevention projects, high-risk intervention, prenatal ancillary support, and training in child abuse prevention. Everyone knows about the Los Angeles County

University of California Medical Center as being the largest obstetrical center in the world. Of all the babies born in the United States, 1 of every 200 babies is born in Los Angeles County and we are now studying the number of mothers who come to us who have not had prior medical care; the estimates are from 5 and 50 percent—we are not sure. But most of our babies are coming to us—despite the services we provide, without the mother having had prior care.

In other counties that are members of NACO, we find that some like in Florida have primary care programs and contracts with the State. Georgia counties, however, are suffering tremendously. Georgia experienced a $2 million reduction in the block grant fund, and 21 counties in Georgia have no obstetrical services; 54 counties have physicians who will not provide services; and we know, and everyone has mentioned, that prevention is certainly less costly than the kinds of problems that result from little prevention.

We would like to make our recommendations to you. The GAO report indicated that there was a great deal of participation, in the maternal and child health block grant planning process, but we feel that counties did not get an opportunity to participate. And we think, since we are deliverers, we should have that opportunity.

We would like to recommend that the appropriation level remain $478 million; that you cap State administrative costs and get the money to the programs, to the service deliveries, cap the State at 15 percent, and designate that the savings be directed to local health departments; and prohibit the State from taking the maternal and child health block grant funds and using the funds to subvert State revenues. We would like to see States continue to meet their current commitments to maternal and child health services.

Senator **Durenberger**. Thank you very much for that statement. Dr. MacQueen?

[Ms. Anderson's written prepared statement follows:]

STATEMENT OF SANDRA J. ANDERSON, DIRECTOR OF GOVERNMENTAL RELATIONS, LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES, FOR THE NATIONAL ASSOCIATION OF COUNTIES, BEFORE THE SENATE FINANCE SUBCOMMITTEE ON HEALTH.

MR. CHAIRMAN, HONORED MEMBERS OF THE SUBCOMMITTEE, MY NAME IS SANDRA ANDERSON. I AM THE DIRECTOR OF GOVERNMENTAL RELATIONS FOR THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES. I AM REPRESENTING THE NATIONAL ASSOCIATION OF COUNTIES*, AND WE WELCOME THIS OPPORTUNITY TO TESTIFY ON ISSUES RELATED TO THE MATERNAL AND CHILD HEALTH BLOCK GRANT.

COUNTY ROLE IN HEALTH CARE

COUNTIES PLAY AN IMPORTANT PART IN OUR HEALTH CARE SYSTEM. AS FINANCERS, PURCHASERS, PROVIDERS, AND PLANNERS OF HEALTH SERVICES, COUNTIES IN ONE WAY OR ANOTHER HAVE A ROLE IN ADDRESSING THE HEALTH CARE NEEDS OF VIRTUALLY ALL AMERICANS.

COLLECTIVELY, COUNTIES HAVE A SPECIAL ROLE IN MEETING THE HEALTH NEEDS OF INDIGENT CITIZENS. IN THE MAJORITY OF STATES, COUNTIES ARE LEGALLY RESPONSIBLE FOR INDIGENT HEALTH CARE OR ALL UNREIMBURSED HEALTH CARE COSTS.** COUNTIES ALSO HAVE A PARTICULARLY SPECIAL ROLE FINANCING AND PROVIDING MATERNAL AND CHILD HEALTH CARE.

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*NACO IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN AMERICA. ITS MEMBERSHIP INCLUDES URBAN, SUBURBAN AND RURAL COUNTIES JOINED TOGETHER FOR THE COMMON PURPOSE OF STRENGTHENING COUNTY GOVERNMENT TO MEET THE NEEDS OF ALL AMERICANS. BY VIRTUE OF A COUNTY'S MEMBERSHIP, ALL ITS ELECTED AND APPOINTED OFFICIALS BECOME PARTICIPANTS IN AN ORGANIZATION DEDICATED TO THE FOLLOWING GOALS: IMPROVING COUNTY GOVERNMENT; ACTING AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT; AND ACHIEVING THE PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

**"COUNTIES LEGAL LIABILITY FOR INDIGENT HEALTH CARE: A SURVEY AND ANALYSIS OF STATE STATUTES AND RULINGS," NATIONAL ASSOCIATION OF COUNTIES, JUNE 1984.

OF THE OVER 2,000 COUNTY HEALTH DEPARTMENTS, 89% FUND AND PROVIDE MATERNAL AND CHILD HEALTH SERVICES, AND 48% ARE THE SOLE PROVIDER OF MATERNAL AND CHILD HEALTH SERVICES. IN MY COUNTY OF LOS ANGELES THE TOTAL BUDGET FOR MATERNAL AND CHILD HEALTH IS $1 BILLION OF WHICH $66 MILLION IS FUNDED BY THE LOCAL PROPERTY TAX. MARICOPA COUNTY, ARIZONA RECEIVES $700,000 IN FEDERAL MATERNAL AND CHILD HEALTH BLOCK GRANT DOLLARS AND THE COUNTY SUPPLEMENTS THAT WITH ANOTHER $1.3 MILLION. THE COUNTY OF PALM BEACH, FLORIDA SPENDS $9 MILLION OF ITS $18 MILLION HEALTH DEPARTMENT BUDGET ON MATERNAL AND CHILD HEALTH, $5 MILLION OF WHICH ARE COUNTY REVENUES.

LOCAL REVENUES SUPPORT THE PROVISION OF COUNTY HEALTH SERVICES FOR MILLIONS OF AMERICANS WHO HAVE NO COVERAGE AND OVERALL HEALTH CARE EXPENDITURES BY COUNTIES ARE ON THE INCREASE. FROM 1981-82, NATIONWIDE, COUNTY EXPENDITURES FOR HEALTH CARE WERE OVER $20 BILLION. DURING THIS YEAR, COUNTIES SAW A 13% INCREASE OVER THE PRIOR YEAR IN HOSPITAL RELATED PAYMENTS ALONE. AS THE LOCAL FISCAL SITUATION HAS TIGHTENED, THE ABILITY TO RAISE OR SHIFT REVENUES TO MEET NEEDS HAS LESSENED. AT THE SAME TIME, COUNTIES HAVE EXPERIENCED RISING HEALTH CARE COSTS ALONG WITH GROWING INDIGENT CARE LOADS. THEREFORE, AN INCREASING NUMBER OF COUNTIES ARE SUPPLEMENTING THE LOCAL HEALTH CARE DOLLARS FROM OTHER GENERAL REVENUE SOURCES NOT PREVIOUSLY TAPPED FOR THAT PURPOSE. FOR EXAMPLE, LOS ANGELES COUNTY NOW SPENDS ITS ENTIRE GENERAL REVENUE SHARING ALLOCATION, $80 MILLION, ON HEALTH CARE.

FINALLY, OF THE 1900 PUBLIC HOSPITALS IN THIS COUNTRY, OVER 900 ARE DIRECTLY AFFILIATED WITH COUNTY GOVERNMENT, PROVIDING A HEALTH "SAFETY NET" FOR CHILDREN OF THE WORKING AND NON-WORKING POOR.

THE MATERNAL AND CHILD HEALTH BLOCK GRANT: CALIFORNIA EXPERIENCE

THE MATERNAL AND CHILD CARE HEALTH SERVICES (MCH) BLOCK GRANT CONSOLIDATED EIGHT CATEGORICAL PROGRAMS AND GAVE STATES THE AUTHORITY TO ADMINISTER THE BLOCK GRANT IN ACCORDANCE WITH CERTAIN BROAD GUIDELINES. THERE WAS A REDUCTION OF NEARLY 25% IN FUNDING FOR THE MCH BLOCK GRANT COMPARED TO FUNDING LEVELS OF PREVIOUS YEARS FOR THE CATEGORICAL PROGRAMS WHICH WERE CONSOLIDATED. THE LOGICAL ASSUMPTION MADE ON THE PART OF STATE AND LOCAL ADMINISTRATORS IN 1981 WAS THAT DRAMATIC CUTS IN SERVICES AND MAJOR CHANGES IN PROGRAM ADMINISTRATION WOULD BE REQUIRED. BUT FOR A NUMBER OF REASONS THESE CUTS AND CHANGES DID NOT OCCUR.

CALIFORNIA RECEIVES $18 MILLION A YEAR UNDER THE MCH BLOCK GRANT. FOUR MILLION DOLLARS IS ALLOCATED TO CRIPPLED CHILDRENS' SERVICES, AND THE REMAINING $14 MILLION FUNDS MATERNAL AND CHILD HEALTH PROGRAMS. IN 1981, STATE OFFICIALS DECIDED TO CONTINUE FUNDING ALL OF THE PROGRAMS AT PREVIOUS FUNDING LEVELS. THIS WAS MADE POSSIBLE BECAUSE OF UNSPENT CARRY-OVER FUNDS FROM EARLIER YEARS AND OF THE 15% FEDERAL SET-ASIDE.

IN 1983, JOBS BILL REVENUES FOR MATERNAL AND CHILD HEALTH AGAIN MADE CUTS UNNECESSARY. THOUGH LOCAL OFFICIALS WERE NOT INVOLVED IN THE STATE DECISION-MAKING PROCESS AND THE STATE RETAINED AN ESTIMATED ONE-THIRD OF THE BLOCK GRANT FOR ADMINISTRATION, LOCAL PROGRAMS DID NOT SUFFER LARGE CUTS. CRIPPLED CHILDRENS' AND MATERNAL CHILD HEALTH PROGRAMS CONTINUED TO GET THE MAJORITY OF THE FUNDS, AND THE REMAINING PROGRAMS MAINTAINED PREVIOUS LEVELS OF SERVICE.

CALIFORNIA HAS BEGUN TO ADDRESS THE ISSUE OF INVOLVING LOCAL OFFICIALS IN THE PLANNING PROCESS. GOVERNOR DEUKMEJIAN SUPPORTS LEGISLATION WHICH WOULD BLOCK GRANT STATE AND FEDERAL MCH FUNDS TO THE COUNTIES WHERE OFFICIALS ARE CLOSER TO THE PROBLEMS AND BETTER ABLE TO PLAN PROGRAMS TO ADDRESS THEM.

LOS ANGELES COUNTY

IN 1980, THE TOTAL POPULATION OF LOS ANGELES COUNTY WAS 7.5 MILLION, AND IS CURRENTLY APPROXIMATELY 7.8 MILLION. OF THIS TOTAL, HISPANICS COMPRISE 27.6%, BLACKS 12.6% AND OTHER NON-WHITES 6.5%. AN ESTIMATED 11.9% OR NEARLY 900,000 PEOPLE WERE LIVING AT OR BELOW THE POVERTY LEVEL. APPROXIMATELY 18% OF LOS ANGELES COUNTY FAMILIES WITH CHILDREN AGED 17 OR YOUNGER WERE LIVING IN POVERTY. BECAUSE OF THE CONTINUED INFLUX OF IMMIGRANTS FROM OUR LATIN NEIGHBORS AND SOUTH-EAST ASIA THE POPULATION AT HIGH RISK FOR MATERNAL AND CHILD HEALTH PROBLEMS IS HIGHER THAN MOST AREAS OF THE COUNTRY.

ONE-HALF OF THE STATE'S HISPANIC AND BLACK BIRTHS OCCUR IN LOS ANGELES COUNTY. MATERNAL MORTALITY IS HIGHER THAN THE NATIONAL RATE. INFANT, NEONATAL, AND PERINATAL MORTALITY RATES ARE TWICE AS HIGH FOR BLACKS AS FOR WHITES. THE LARGEST NUMBER OF POST-NEONATAL DEATHS OCCURRED TO HISPANICS. BIRTH RATES FOR BLACK TEENAGERS ARE MORE THAN TWICE THAT FOR WHITES WHILE BIRTHS TO TEEN-AGERS OF ALL GROUPS ACCOUNT FOR MORE THAN 14% OF ALL BIRTHS EACH YEAR.

THERE ARE STILL SERIOUS PROBLEMS WITH COMMUNICABLE DISEASES, CHILD ABUSE, LEAD CONTAMINATION, TEENAGE SUICIDES, AND THE GROWING PROBLEM OF SUBSTANCE ABUSE.

THIS YEAR THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES RECEIVED $1.8 MILLION FOR MCH PROGRAMS AS WELL AS FUNDS FOR CRIPPLED CHILDRENS' SERVICES. FUNDS ARE USED IN A VARIETY OF PROJECTS THAT INCLUDE DEVELOPING A COMPREHENSIVE PLAN FOR MATERNAL, CHILD, AND ADOLESCENT HEALTH CARE; PROVIDING SUPPORT SERVICES LIKE HEALTH EDUCATION AND NURSING TO 600 PRENATAL AND POST-PARTUM PATIENTS IN THE SOUTHERN PART OF THE COUNTY; PROVIDING SCREENING, LAB TESTS, AND COUNSELING TO 5,000 PATIENTS IN A HIGH RISK AREA OF THE NORTHERN COUNTY; TRAINING 8,000 PERSONS TO PREVENT AND TREAT CHILD ABUSE; AND PROVIDING SUPPORT SERVICES AT THE ROYBAL COMPREHENSIVE HEALTH CENTER FOR PREGNANT PATIENTS LIVING IN THE EAST AND WEST AREAS OF THE COUNTY.

OTHER COUNTY EXPERIENCES

PALM BEACH COUNTY, FLORIDA HAS DEVELOPED AND PROVIDES A MAJOR PRIMARY CARE PROGRAM FOR MOTHERS, INFANTS AND CHILDREN. THE PROGRAM IS FUNDED WITH MCH AND COUNTY DOLLARS, AUGMENTED BY A SLIDING FEE SCALE. THE COUNTY UTILIZES THE CREASY FORMULA TO IDENTIFY WOMEN AT RISK OF DELIVERY OF LOW BIRTH WEIGHT BABIES. A BENEFIT PACKAGE COMBINING TRADITIONAL PUBLIC HEALTH WITH MEDICAL CARE DEVELOPED BY THE COUNTY AND NEGOTIATED WITH PROVIDERS INCLUDES PRENATAL, POST PERINATAL, AND NEONATAL CARE. PREVENTION AND EDUCATION, FOCUSING ON LIFESTYLE AND NUTRITION ARE STRESSED. THE COUNTY CONTRACTS WITH FULL-TIME PEDIATRICIANS, OBSTETRICIANS AND A CERTIFIED MID-WIFE PROGRAM. IN ORDER TO ENSURE CONTINUITY OF CARE, THE COUNTY HOLDS REGULAR MEETINGS BETWEEN THE PEDIATRICIANS AND OBSTETRICIANS AND INVOLVES PEDIATRICIANS IN THE DELIVERY.

PALM BEACH COUNTY HAS A LONG HISTORY IN PRIMARY HEALTH CARE AND IN WORKING WITH THE STATE OF FLORIDA. THE COUNTY REPORTS THAT THE STATE INVOLVES COUNTIES IN REGULARLY SCHEDULED PLANNING MEETINGS REGARDING THE USE OF MCH FUNDS AND PRIMARY CARE IN GENERAL.

IN THE STATE OF GEORGIA THE LACK OF MATERNAL, CHILD AND INFANT CARE SERVICES, IN COMBINATION WITH REDUCTIONS OF MCH FUNDS APPEARS TO HAVE HAD DIRE CONSEQUENCES IN A STATE WHERE THERE ARE MANY RURAL, POOR COUNTIES WITH SPARSE RESOURCES AND LITTLE OR NO SERVICES. IN 39 OF THE 159 COUNTIES, THERE IS NO HOSIPTAL; 21 COUNTIES WITH HOSPITALS OFFER NO OBSTETRIC SERVICES; 47 COUNTIES ARE WITHOUT PHYSICIANS PROVIDING OBSTETRIC CARE; 14 COUNTIES HAVE PHYSICIANS WHO PROVIDE OBSTETRIC SERVICES, BUT WILL NOT ACCEPT MEDICAID PATIENTS; 54 COUNTIES HAVE PHYSICIANS WHO PROVIDE OBSTETRIC SERVICES, BUT WILL NOT ACCEPT INDIGENT PATIENTS. (I WOULD POINT OUT HERE THAT THE INDIGENT POPULATION OF MOTHERS AND CHILDREN IS LARGE, AS GEORGIA'S MEDICAID PROGRAM COVERS ONLY THE CATEGORICALLY NEEDY, EXCLUDING FIRST TIME PREGNANT WOMEN, AND CHILDREN FROM TWO-PARENT FAMILIES FROM COVERAGE.) IN SEVEN COUNTIES THERE IS NO PRENATAL CARE AVAILABLE.

GEORGIA HAS LOST $2 MILLION IN MCH BLOCK GRANT FUNDING. THIS REDUCTION IN FUNDING HAS SEVERELY IMPACTED THE STATE'S HIGH RISK/TERTIARY CARE CENTERS, WHICH COUNTIES FUNNEL IDENTIFIED HIGH RISK CHILDREN INTO. DIAGNOSTIC AND TREATMENT SERVICES HAVE BEEN FRAGMENTED AND REDUCED. WHEN THE STATE OF GEORGIA HELD MCH BLOCK GRANT HEARINGS, THEY LEARNED THAT COUNTY DOLLARS FOR MATERNAL, CHILD AND INFANT CARE ARE SPENT ON THE HIGHER COST HOSPITAL EMERGENCY AND MEDICAL SERVICES RATHER THAN ON HEALTH DEPARTMENTS AND BASIC PREVENTIVE PRIMARY HEALTH CARE, AS THE RESOURCES NEEDED TO DEVELOP A BASIC SYSTEM OF CARE ARE SO SEVERELY LIMITED.

WHAT ARE THE RESULTS DUE TO THIS SEVERE SHORTAGE OF CARE IN THIS STATE? IN 1982, 394 INFANTS DIED BETWEEN 28 DAYS AND ONE YEAR OF AGE; 7,604 OF 90,000 BABIES WERE BORN UNDERWEIGHT AND 1,189 DIED BEFORE THEIR FIRST BIRTHDAY. IN 1980, 975 WOMEN RECEIVED ABSOLUTELY NO PRENATAL CARE AND IN 1982 THIS NUMBER INCREASED TO 1,280. FROM 1978-82, 29,204 WOMEN WHO GAVE BIRTH HAD LESS THAN FOUR PRENATAL VISITS.

GAO REPORT

THE GENERAL ACCOUNTING OFFICE REPORT ON THE MCH BLOCK GRANT PUBLISHED ON MAY 7, 1984, REACHED SEVERAL CONCLUSIONS WITH WHICH WE AGREE REGARDING THE EXPERIENCE OF ADMINISTERING THE MCH BLOCK GRANT IN CALIFORNIA. MAJOR CUTS DID NOT OCCUR AND AVAILABLE FUNDS TENDED TO BE USED TO MAINTAIN BROADER PROGRAMS. THERE WERE ONLY MINIMAL CUTS AND CHANGES IN STAFFING AT THE STATE LEVEL, AND STATE OFFICIALS RATED THE BLOCK GRANT MORE FLEXIBLE. BUT CONTRARY TO THE GAO REPORT, IT WAS OUR EXPERIENCE THAT LOCAL PARTICIPATION IN THE DECISION-MAKING PROCESS DID NOT INCREASE AND THE RETENTION BY THE STATE OF AT LEAST ONE-THIRD OF THE REVENUES FOR ADMINISTRATIVE PURPOSES GAVE US CAUSE FOR CONCERN.

NACo SURVEY

THE FEDERAL CONTRIBUTION TO MANY FEDERALLY FUNDED HEALTH SERVICES HAS DECLINED SINCE BLOCK FUNDING BEGAN, ACCORDING TO A NACo SAMPLE OF 51 COUNTY HEALTH DIRECTORS IN 24 STATES. IF THE FUNDS ARE DISCONTINUED, THESE PROGRAMS WILL BE EITHER CURTAILED OR ELIMINATED.

TWENTY-ONE RESPONDENTS STATED THAT SINCE BLOCK GRANT FUNDING, THERE WAS LESS MONEY AVAILABLE FOR DIRECT HEALTH SERVICES. THE DECLINE, HOWEVER, WAS NOT UNIFORM. TEN HEALTH DIRECTORS REPORTED NO CHANGE IN FEDERAL FUNDING AND 13 REPORTED AN INCREASE IN FUNDS.

WHILE NOT ALL COUNTIES ANSWERING THE SURVEY FACED FEDERAL CUTBACKS, COUNTY HEALTH DIRECTORS PREDICTED THAT FEDERALLY SUPPORTED HEALTH SERVICES WOULD SUFFER IN FEDERAL FUNDS WERE WITHDRAWN. LOCAL TAX REVENUES, THEY REPORTED, COUND NOT MAKE UP THE DIFFERENCE.

ACCORDING TO RESPONDENTS, 53 PERCENT OF LOCAL FEDERALLY-SUPPORTED PROGRAM WOULD BE ELIMINATED AND 44 PERCENT WOULD BE CURTAILED. FEWER THAN 3 PERCENT OF RESPONDENTS COULD RELY ON LOCAL REVENUES TO CONTINUE SERVICES AT THEIR CURRENT LEVEL.

PROGRAMS THAT LOCAL HEALTH DIRECTORS REPORTED RECEIVING SUBSTANTIAL AMOUNTS OF FEDERAL ASSISTANCE FOR INCLUDE MATERNAL AND CHILD HEALTH (MCH) PROGRAMS, SPECIFIED NON-MCH PROGRAMS WITHIN THE MCH BLOCK GRANT AND PRIMARY CARE. THESE PROGRAMS RECEIVED ON THE AVERAGE MORE THAN TWO-THIRDS OF THEIR FUNDING FROM FEDERAL SOURCES. RESPONDENTS STATED THAT IF FEDERAL FUNDS FOR THESE PROGRAMS WERE WITHDRAWN, ABOUT HALF THE SERVICES WOULD BE DROPPED AND NEARLY ALL OF THE OTHERS WOULD FACE DECREASES. ONLY TWO COUNTIES REPORTED THAT MCH PROGRAMS COULD CONTINUE AT THEIR CURRENT SERVICE LEVELS IF FEDERAL FUNDS WERE WITHDRAWN.

THE SURVEY ALSO FOUND THAT BLOCK GRANTS DID NOT NECESSARILY IMPROVE THE ABILITY OF COUNTY HEALTH DEPARTMENTS TO TARGET AVAILABLE FUNDS. THE NEW FUNDING METHOD MAY HAVE ALLOWED STATES MORE FLEXIBILITY, BUT THAT FLEXIBILITY WAS NOT ALWAYS DELEGATED TO LOCAL GOVERNMENT. WHILE 16 RESPONDENTS REPORTED GREATER FLEXIBILITY, 18 REPORTED NO CHANGE AND 10 REPORTED LESS FLEXIBILITY TO TARGET FUNDS COMPARED TO THEIR EXPERIENCE UNDER CATEGORICAL FUNDING.

CLOSELY RELATED TO THE ABILITY TO TARGET FUNDS IS THE DEGREE TO WHICH COUNTY HEALTH DEPARTMENTS PARTICIPATED IN THE STATE IMPLEMENTATION OF BLOCK GRANTS, INCLUDING THE ALLOCATION OF FUNDS.

IN A LARGE NUMBER OF CASES, LOCAL INPUT WAS LACKING; 50 PERCENT OF THE HEALTH DIRECTORS REPORTED NO PARTICIPATION. THAT LACK OF INPUT IS REFLECTED IN THEIR EVALUATIONS OF THE PROCESS. TWENTY-TWO RESPONDENTS THOUGHT THAT THE PROCESS TO INSURE THEIR INPUT WAS NOT SATISFACTORY, COMPARED TO 16 WHO FELT THAT IT WAS SATISFACTORY.

IN THOSE CASES WHERE THE STATE DID SEEK LOCAL INPUT, IT DID SO IN A VARIETY OF WAYS. IN SOME CASES, STATE AGENCIES ASKED THE LOCAL HEALTH DEPARTMENT OR LOCAL AREA ADVISORY COMMITTEES FOR RECOMMENDATIONS ON LOCAL PRIORITIES OR TO COMMENT ON A STATE ALLOCATION PLAN. IN OTHER CASES, STATE AGENCIES ASKED STATE-WIDE ORGANIZATIONS OF LOCAL HEALTH DIRECTORS FOR THEIR INPUT. IN AT LEAST ONE STATE, A COMMITTEE COMPOSED OF BOTH LOCAL AND STATE OFFICIALS SUBMITTED RECOMMENDATIONS. THERE WAS, HOWEVER, NO CLEAR RELATIONSHIP BETWEEN ANY SPECIFIC TYPE OF LOCAL PARTICIPATION AND DEGREE OF SATISFACTION CONCERNING THAT PROCESS.

IN RESPONSE TO A SURVEY REQUEST FOR COMMENTS REGARDING PROPOSED CHANGES IN BLOCK GRANT LEGISLATION, SOME COUNTY HEALTH DIRECTORS INDICATED A DISSATISFACTION WITH THE EXTENT OF LOCAL INFLUENCE IN TARGETING FEDERAL FUNDS. SOME DIRECTED THEIR COMMENTS AT STATE GOVERNMENT, ADVOCATING A GREATER ROLE FOR LOCAL GOVERNMENT IN DETERMINING ALLOCATION OF HEALTH FUNDS. TWO SUGGESTED THAT THEIR STATE HAD RETAINED A DISPROPORTIONATE SHARE FOR ADMINISTRATIVE PURPOSES. OTHER RESPONDENTS SAID THAT THE STATE SHOULD BE BYPASSED ENTIRELY AND FUNDING SHOULD GO DIRECTLY TO LOCALITIES.

HOWEVER, OTHER ADVOCATES OF GREATER LOCAL DECISION-MAKING WERE NOT CRITICAL OF THE STATE ROLE. ONE DIRECTOR, FOR EXAMPLE, PROPOSED CHANGES IN FEDERAL REGULATIONS THAT WOULD PERMIT THE STATE AS WELL AS THE COUNTY GREATER FLEXIBILITY. ANOTHER DIRECTOR HAD A DIFFERENT VIEW, SUGGESTING THAT BLOCK GRANTS HAVE GIVEN STATES AND LOCALITIES NEEDED FLEXIBILITY.

FINALLY, LOCAL AND STATE GOVERNMENTS HAVE FREQUENTLY CRITICIZED THE PAPERWORK REQUIRED BY FEDERAL AID PROGRAMS. ALTHOUGH NOT AN EXPLICIT GOAL OF BLOCK GRANT FUNDING, PART OF ITS OVERALL DIRECTION HAS BEEN TO REDUCE STATE AND LOCAL REPORTING REQUIREMENTS. IT WAS CLEARLY UNSUCCESSFUL IN DOING SO AT THE LOCAL LEVEL. TWENTY HEALTH DIRECTORS REPORTED MORE PAPERWORK UNDER BLOCK GRANT FUNDING AND 22 REPORTED NO CHANGE, ONLY TWO REPORTED A REDUCTION IN PAPERWORK.

RECOMMENDATIONS

IN CONCLUSION, THE IMPACT OF ANY FEDERAL FUNDING CUTS WOULD BE SERIOUS FOR PREGNANT WOMEN AND CHILDREN IN LOS ANGELES COUNTY THROUGHOUT CALIFORNIA AND THE REST OF THE NATION. THE NEED FOR HELP REMAINS GREAT AND WILL CONTINUE TO EXIST AS PEOPLE FLOW INTO THE UNITED STATES FROM COUNTRIES SUFFERING FROM POLITICAL AND SOCIAL UNREST AND AS POVERTY AND ILLITERACY COMPLICATES OUR ABILITY TO EDUCATE AND TO ENSURE GOOD HEALTH CARE.

THEREFORE, WE MAKE THE FOLLOWING RECOMMENDATIONS WITHIN THE CONTEXT OF BROAD NACo POLICY ON BLOCK GRANTS WHICH STATES THAT "EMPHASIS SHOULD BE ON SAVINGS TO TAXPAYERS, AND INCREASED FLEXIBILITY AND SIMPLICITY IN ADMINISTERING FEDERAL PROGRAMS AT ALL LEVELS OF GOVERNMENT; AND NOT JUST A SHIFTING OF COSTS FROM FEDERAL TO LOCAL TAXPAPERS; AND THE LOW INCOME POPULATION OF THIS COUNTRY SHOULD NOT BEAR A DISPROPORTIONATE SHARE OF FEDERAL REDUCTIONS IN SPENDING FOR BLOCK GRANT PROGRAMS."

1. A $478 MILLION AUTHORIZATION LEVEL FOR THE MCH BLOCK GRANT.
2. CAP STATE ADMINISTRATIVE COSTS AT 15%. IN CALIFORNIA, THE STATE RETAINED ONE-THIRD OF THE MCH FUNDS FOR ADMINISTRATIVE PURPOSES. THE STATE OF MICHIGAN PASSED THE REDUCTION IN FEDERAL FUNDING ON TO COUNTIES. EACH COUNTY RECEIVED A 25% CUT IN MCH DOLLARS, WHILE THE STATE MAINTAINED ITS FULL ADMINISTRATIVE CAPABILITY.
3. MCH BLOCK GRANT LEGISLATION SHOULD SPECIFICALLY PROHIBIT STATES FROM USING MCH FUNDS TO SUPPLANT STATE DOLLARS.
4. USE THE RECOMMENDED INCREASED AUTHORIZATION AND DOLLARS GENERATED BY CAPPING STATE ADMINISTRATIVE COSTS TO EARMARK MCH DOLLARS TO LOCAL HEALTH DEPARTMENTS FOR THE DEVELOPMENT AND PURCHASE OF LOW COST CARE BASED ON INTRA-COUNTY COMPACTS. THIS WOULD ALLOW COUNTIES WITH SCARCE RESOURCES, AS THOSE DESCRIBED IN GEORGIA, TO PURCHASE NECESSARY CARE FROM OTHER COUNTIES OR PROVIDERS. A PORTION OF THESE FUNDS SHOULD BE ALLOWED FOR TRANSPORTATION. IN MANY INSTANCES, A MOTHER AND/OR CHILD NEEDS TRANSPORTATION TO ANOTHER COUNTY WHERE DOCTORS, HOSPITALS AND SERVICES EXIST. RURAL COUNTIES HAVE MOST OFTEN CITED THE LACK OF TRANSPORTATION SERVICES AS A MAJOR BARRIER TO CARE.

THIS COMPLETES OUR RECOMMENDATIONS. I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE THIS COMMITTEE. I WILL BE PLEASED TO ANSWER ANY QUESTIONS AT THIS TIME.

STATEMENT OF JOHN C. MacQUEEN, M.D., CODIRECTOR, NATIONAL MATERNAL AND CHILD HEALTH RESOURCE CENTER, IOWA CITY, IA, ON BEHALF OF THE ASSOCIATION OF MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S PROGRAMS

Dr. **MacQueen**. Senator Durenberger, I appreciate the opportunity of testifying before you. I speak on behalf of the Association of the Maternal and Child Health and Crippled Children's Programs. This association is composed of the directors of these State programs.

At the onset, I would like to acknowledge the assistance of the National Maternal and Child Health Resource Center, which provides information to the association in the preparation of my written testimony.

Because the time is late and because you have a copy of my written testimony, I will speak briefly.

The association is grateful to the GAO for the preparation of its report about the MCH block grant programs. It describes the transitional period during which the State MCH/CC programs have been reorganized.

On the other hand, and on behalf of the Directors, I want to clarify the funding situation. The State MCH and crippled children's programs are facing severe funding problems through the combination of a series of situations, not only have to adjust to the reduction in Federal MCH support that occurred in 1981, but to cut back in other Federal and State programs—including medicaid. The children who we cut from those programs are now requesting services from the State MCH/CC programs.

The summary of the GAO report state that the States have made up for the Federal cuts, but a more careful review of the data in the report shows that if the large increase made by Texas is not included, the statement would not be true, for the other reporting States.

We are further concerned that the report does not adequately recognize the fasting of inflation. Reference is made to a 7-percent inflationary rate, but in CC programs that spend most of the State program dollars pay for hospital services, where the inflation rate is 15 to 20 percent. So in fact we have fallen far behind.

We have no disagreement with the statistics in the report, but we had hoped that the GAO would study the other factors that influence our programs. The amount of money spent does not provide the total picture in these programs.

Speaking for the administrators of the programs, I would report that there have been benefits from the block grant legislation. It has allowed us, encouraged us to assess our programs, to tailor our programs, and to reallocate our funds.

I would give you an example. It concerns the activities of the State MCH/CC programs related to lead poisoning prevention. In January of this year the National Maternal and Child Health Resource Center conducted a study of 10 States. The center found that all of the States had conducted assessment studies. On the basis of those assessments a few Western States had decided that lead poisoning was a very limited problem, if a problem at all, and they elected not to develop a State program. On the other hand, some of the very large Eastern States identified that lead poisoning was an important problem and increased the amount of money spent to develop expanded statewide programs, and as a result of the flexibility in the block grant legislation were integrating their lead programs into their WIC programs and MCH with child programs.

I would propose to you that what they have done is what you were talking with Senator Bumpers about is morning. As a result of the flexibility of the block grant legislation the States have assumed the responsibility for determining their needs, and for developing programs to meet those needs.

Confronted with the previously referred to funding restraints, the State MCH programs used the flexibility of the block grant to make other major programmatic decisions. One of the most important decisions was that made by most State MCH programs, to discontinue their programs of projects. Those programs provided a variety of services, including high-risk intensive care for a few children. A number of States revised these programs and concluded, "If we have only limited dollars, we'll put them in the prevention programs conducted by the MCH programs where many children will be served."

Last, the CC programs are concerned that in the summary of the GAO report it says that the State CC programs have not cut back although in the body of the report it correctly describes how the CC programs have decreased their services by changes in age eligibility, scope of services provided, length of services paid for etc. In summary for financial reasons the State CC have cut back in the services they provide.

In general we do believe that the block grant legislation is well designed and is in the process of being successfully implemented. If, however, the MCH block grant programs are to fulfill their mandate as set forth in the legislation, it is critically important for the Federal funding for these programs to be increased.

Thank you.

Senator DURENBERGER. Thank you very much.

[Dr. MacQueen's written prepared statement follows:]

TESTIMONY OF JOHN C. MACQUEEN, M.D.

SUMMARY

I. Federal Funding of state MCH Block Grant Programs

State maternal and child health (MCH) programs and crippled children's (CC) programs are facing severe funding problems due to the combined effect of the following :

A. Reduction of federal funding of the state MCH programs at the time of the creation of the Block Grant and to failure of these programs to receive increases in funding comparable to the inflation in the costs of health care which they provide or purchase.
B. Federal Medicaid cutbacks and loss of federal funds for other programs which had been utilized to support MCH activities.
C. Uncertain and inadequate state funding.
D. Inflation in health care costs.
E. Increase in demand for services from MCH and CC programs.

II. Implementation of the MCH Block Grant Legislation

The implementation of the MCH Block Grant legislation has had the following benefits:

A. The MCH Block has allowed states to assess their needs and to allocate resources and tailor programs accordingly.
B. In some states, the MCH Block Grant has produced more of a statewide focus in the planning and programming of center types of maternal and child health activities.
C. The MCH Block has generally facilitated the coordination of MCH block programs and the integration of services for mothers and children.
D. The MCH Block grant has generally simplified the administration of programs and services.

In a number of states, the creation of the MCH Block Grant has not produced major structural or programmatic changes in state MCH programs. Many of the changes in state MCH Block Grant programs attributed to the creation of the Block Grant are, in fact, attributable to the severe funding constraints under which these programs have had to operate since the creation of the Block Grant.

III. Setting of Priorities and Allocation of Resources Under the MCH Block Grant

Confronted with severe funding constraints, state MCH and CC programs have had to curtail programs and services and have been unable to meet the demand for and need for services.

- State MCH programs have made cutbacks in the provision of comprehensive services in order to provide needed basic services to mothers and children and have made cutbacks in health services for children in order to provide needed services to pregnant women and infants.
- State CC programs have restricted program eligibility and limited the type and length of time that services will be provided.

Mr. Chairman, I appreciate the opportunity to appear before you to testify on behalf of the Association for Maternal and Child Health and Crippled Children's Programs which is made up of the administrators of the State MCH Block Grant programs, regarding the implementation of the Title V Maternal and Child Health Block Grant (MCH Block Grant) legislation.

At the outset, the Association would like to acknowledge the assistance of the National Maternal and Child Health Resource Center which provided much of the data upon which this testimony is based.

I. DESCRIPTION OF MCH BLOCK GRANT PROGRAMS

Title V of the Social Security Act, which was enacted in 1934, provided federal assistance to the states for a maternal and child health program (MCH program) for low-income mothers and children and a crippled children's program (CC program) for children with handicapping conditions or potentially handicapping conditions.

The Title V Maternal and Child Health Block Grant legislation, enacted in 1981, consolidated the Title V Maternal and Child Health program and the Title V Crippled Children's program with the following programs: The Supplemental Security Income for Blind and Disabled Children, the Lead Poisoning Prevention Program, the Sudden Infant Death Syndrome Program, the Genetic Diseases Program, and the Hemophilia Diagnostic and Treatment Center Program.

At the state level, the Title V MCH Block Grant programs are public health programs designed to improve the health status of all mothers and children by promoting an optimal health care delivery system for mothers and children. The state agencies which administer the MCH Block Grant programs perform several functions, including planning, coordination of existing services, introduction of innovative methods of health care into the health care delivery system, training and education of health professionals, the provision of direct services, and outreach services.

The MCH Block Grant programs have a strong preventive thrust, and a number of studies have found them to be cost-effective and highly successful in improving the general health of mothers and children, in reducing infant mortality and morbidity, and in reducing handicapping conditions and serious illness and their complications.

II. IMPACT OF REDUCTION OF AUTHORIZED FEDERAL FUNDING LEVEL FOR MCH BLOCK GRANT PROGRAMS AND FAILURE TO PROVIDE FOR ANNUAL INFLATION INCREASES IN THIS FUNDING LEVEL AND OTHER FUNDING PROBLEMS OF MCH BLOCK GRANT PROGRAMS

A recent report of the National Maternal and Child Health Resource Center indicates that the state MCH Block Grant programs are having severe funding problems. More specifically, the report reveals that the reduction in federal funding for the state MCH Block Grant programs at the time of the enactment of the MCH Block Grant legislation and the failure of federal appropriations to keep pace with inflation together with uncertain and inadequate state funding, Medicaid cutbacks, loss of federal funds for other programs used for state maternal and child health activities, inflation in health care costs, and increased demand for services has meant that these programs do not have sufficient funding to carry out their mandate under the MCH Block Grant legislation.

Federal Funding of MCH Block Grant

The federal MCH Block Grant legislation, enacted in 1981, provided an authorized funding level for the MCH Block Grant of $373 million. This represented an overall cut of 18% in funds available for state MCH Block Grant programs, and it represented a much greater cut of about 38% in the funds available for discretionary grants for Special Projects of Regional and National Significance supported with the 15% of the MCH Block Grant appropriation "set-aside" for this purpose.

The FY 1983 appropriation for the MCH Block Grant was $373 million. In addition, there was a special appropriation of $105 million under P.L. 98-8, the Emergency Jobs Bill, bringing the total funding for that year to $478 million. The FY 1984 appropriation for the MCH Block Grant is $399 million.

Since the 1981 creation of the MCH Block Grant and the accompanying federal funding cuts, federal funding of MCH Block Grant programs has not kept pace with inflation. The FY 1984 constant service level for the MCH Block Grant is $607,252,000, based upon the FY 1980 appropriation and assuming maintenance of real purchasing power. This funding level is $234 million more than the current authorization level of $373 million and $208 million more than the current appropriation of $399 million.

Federal Funding of Programs other than MCH Block Grant Programs

In many states, the reduction in federal funding for MCH Block Grant programs has been compounded by the loss of federal funding from other categorical health and human service programs which was being utilized to support maternal and child health and crippled children's services.

The MCH Block Grant programs have also been negatively affected by reduction in federal and state funding of the Title XIX Medicaid program because the MCH Block Grant programs provide services to a substantial number of mothers and children who are not eligible for the Medicaid program but who are in need of care or who are eligible for the Medicaid program, but who need care not covered by the Medicaid program.

State Funding of MCH Block Grant Programs

State funding of MCH Block Grant programs varies considerably from state to state. In some states, there is no state appropriation or only a minimal state appropriation for these programs which consequently are very dependent on federal MCH Block Grant funds. (In such states, the requirement that states match federal MCH Block Grant formula funds received may be satisfied by state in-kind contributions, local funds, and funds and in-kind contributions from contractors.) In other states, these programs are heavily state funded, and the federal MCH Block Grant funds constitute only a small proportion of total program budgets. In still other states, these programs receive substantial state funding.

Just as the level of state funding of MCH Block Grant programs has varied, the responses of the states to reductions in federal funding of MCH Block Grant programs have varied. In 1981-82, the most typical pattern was for states to increase state funding of MCH Block Grant programs, although such increases in state funding were generally not sufficient to make up for the effects of the federal funding reductions and inflation. During the period 1982-84, however, many states began to experience financial difficulties, and, as a result, in the majority of states these programs received little or no increase in state funding and, in some states, state funding was actually reduced.*

Inflation in Health Care Costs

Federal funding and, in most cases, state funding of MCH Block Grant programs has not kept pace with inflation in health care costs. In recent years, these costs have exceeded the average inflation rate as measured by the Consumer Price Index, and the MCH Block Grant programs essentially have little or no control over these costs.**

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* Although this occurred in some of the states which were the subject of a recent U.S. General Accounting Office Report entitled The Maternal and Child Block Grant: Program Changes Emerging Under State Administration, it is not reflected in the GAO report, apparently because it occurred after the survey upon which the report was based.

**The inflation in health care costs with which the state MCH Block Grant programs have had to cope has far exceeded the inflation factor of 7% per year during the period 1981-83 utilized by the GAO report in adjusting state expenditures for state MCH Block Grant programs.

The state crippled children's programs, which have traditionally provided or purchased in-patient hospital services, out-patient services and support services for children with handicaps and chronic or life-threatening illness, have been particularly hard hit by the inflation in health care costs, especially hospital costs. There have been large increases in the cost of in-patient hospital care, ranging from 15 to 34%, for children enrolled in state crippled children's programs, due to the inflation in the cost of this care. While the increases in the cost of out-patient care for children enrolled in state crippled children's programs have not been as dramatic as the increases in the cost of in-patient hospital care for these children, the rise in out-patient costs has been substantial for many programs.

Inflation in health care costs has also negatively affected the state maternal and child health programs. Thus, state maternal and child health programs which pay for needed in-patient hospital care for pregnant women and seriously ill newborns have been confronted with financial problems due to inflation in health care costs comparable to the already described problems of the state crippled children's programs.

Increase in Demand for MCH Block Grant Services

Even before cuts in federal funding were made in 1981, these programs were unable to meet the demand for services for mothers and children whom they were mandated to serve. At the same time that these programs have been faced with limited federal and state funding and the effects of inflation, they have had to cope with an increased demand for services.

Since 1981, there has been a substantial increase in demand for public health services supported by state maternal and child health programs with MCH Block Grant funds, and this demand appears to be continuing. State maternal and child health programs have also experienced changes in the make-up of their caseloads. A higher percentage of mothers and children served by these programs are uninsured. This has meant that these programs are having to assume all or almost all of the costs of care for an increasing number of mothers and children.

The state crippled children's programs, which utilize MCH Block Grant funds for services to children with handicapping conditions or potentially handicapping conditions and chronic diseases, similarly report a substantial rise in applicants and referrals. An increasing number of children enrolled in state crippled children's programs also have no public or private third-party coverage and lack the financial resources to pay for care. Hence, the expenditures of these programs for enrolled children are rising.

The increase in demand that state MCH Block Grant programs are observing appears to be an outgrowth of several interrelated factors. At the state and local level, MCH Block Grant programs report that there have been widespread cutbacks in Medicaid programs with the result that mothers and children no longer eligible for Medicaid benefits have turned to state MCH and CC programs for assistance. State MCH Block Grant programs also report that more and more mothers and children, finding themselves without private insurance coverage and unable to purchase care in the private sector due to family unemployment have turned to state MCH Block Grant programs for assistance, and it should be borne in mind in this regard that, although the economy has improved, there remain states with high unemployment rates and areas within states with high unemployment rates. In addition, state MCH Block Grant programs report that they are seeing a greater number of families where there is an employed individual who has no insurance coverage through the workplace or who has insurance coverage but the coverage does not extend to their dependents.

III. IMPACT OF THE MCH BLOCK GRANT LEGISLATION

The enactment of the MCH Block Grant legislation and its implementation had the effect of increasing the responsibilities of state maternal and child health programs and state crippled children's programs, particularly in assessing the state's maternal and child health needs, the setting of maternal and child health program priorities and allocation of resources to these programs, and the monitoring of maternal and child health activities. State administrators of these programs have developed and utilized a variety of policies and procedures in carrying out these responsibilities.

While it is difficult [illegible] generalize about the impact of the MCH Block Grant legislation, it does appear to have had a positive impact overall from the standpoint of the state maternal and child health and crippled children's programs. Among the major benefits of the MCH Block Grant have been the following:

- The states differ in the nature and extent of their maternal and child health problems and the resources available to deal with these problems, and the MCH Block Grant has allowed states to assess their maternal and child health needs and to set their priorities and allocate their resources in accordance with their own individual needs.

- In some states, the MCH Block Grant has produced more of a statewide focus in the planning and programming of certain types of maternal and child health activities which were formerly conducted through federal categorical programs.

- The MCH Block Grant has increased the potential for and facilitated greater coordination of MCH Block Grant programs and greater integration of health and health-related services for mothers and children.

- The MCH Block Grant has generally simplified program administration.

It must be stressed, however, that in a number of states, the creation of the MCH Block Grant has not produced major structural or programmatic changes in state MCH programs. It must also be stressed that many of the changes in state MCH Block Grant programs attributed to the creation of the Block Grant are, in fact, attributable to the severe funding constraints under which these programs have had to operate since the creation of the Block Grant.

IV. SETTING OF PRIORITIES AND ALLOCATION OF RESOURCES UNDER THE MCH BLOCK GRANT

Confronted with severe funding constraints, administers of state maternal and child health and crippled children's programs have had great difficulty in reconciling competing demands for maternal and child health dollars. It must be emphasized in this regard that these programs have developed a variety of mechanisms for assessing needs and securing input from interested individuals, groups and organizations in order to assure that these dollars are well spent. Cutbacks, however, in needed programs and services have been unavoidable because of insufficient funding.

While here again generalizations are difficult, there are two apparent trends with respect to state maternal and child health programs stemming from insufficient funding that are worthy of mention. First, many of these programs have been compelled to cutback on the provision of comprehensive services in order to provide needed basic services to the greatest possible number of mothers and children. Second, many of these programs have been compelled to cutback on child health services in order to provide needed basic services to pregnant women and infants. Faced with insufficient funding, many state crippled children's programs have likewise had to significantly restrict program eligibility in terms of income, diagnostic conditions, and age and to significantly limit the type of services which will be provided and the length of time that services will be provided.*

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*The GAO report eroneously reports state crippled children's programs have not dropped any services in the states surveyed.

It should be noted that as a result of the special supplemental appropriation for the MCH Block Grant under P.L. 98-8, the Emergency Jobs Bill, in late FY 1983, state maternal and child health and crippled children's programs increased resources for services that had received funding reductions.* These funds, however, have been already expended or will be expended by the end of FY 1984.*

CONCLUSION

The MCH Block Grant legislation is well designed and is in the process of being successfully implemented. If, however, the MCH Block Grant programs are to be able to fulfill their mandate as set forth in this legislation, it is of critical importance that federal funding for these programs be increased.

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*For example, the GAO report states that in the majority of states surveyed which had lead poisoning prevention activities, funding for these activities was reduced between 1981 and 1983. However, states with such activities, including several of the states GAO surveyed, utilized Emergency Jobs Bill monies to increase funding for these activities.

Senator DURENBERGER. Let me ask the first two witnesses if they would comment from their experience on one of the observations that Dr. MacQueen made—I guess we haven't explored this much with the other witnesses—and that is, what has happened in the last 3 years to the cost of services?

We know what has happened to the revenue from Federal sources, and we have information from GAO as to how other people are chipping in in a variety of ways; but perhaps each of you, from your observations, might comment on what has actually happened to the cost of service delivery.

Dr. MacQueen made reference of course to hospital costs, which we know something about, but there are other costs in some of these programs. Do either of you want to tackle that question?

Mr. DURMAN. I can't give you the detail on the specific costs of specific services. I can give you a sense of some of the issues that we wrestled with as we attempted to try to assess whether increases in nominal spending were really keeping up with the real change in the cost of services.

Services that are hospital based, and many of the crippled children services are those, have been escalating very rapidly, and the 7-percent figure that we have used as a general approximation is probably an underestimate, possibly a significant underestimate of what has been going on in that program in particular. Part of the reason why dollars have been maintained relatively more in crippled children's services is simply that the cost of those services has escalated far more rapidly than the cost of some of the other services.

When services are out of the hospital, clinic-based and less subject to third-party reimbursement, they have escalated less rapidly. Our estimate was that the 7-percent figure was not inappropriate for nonhospital based services.

Senator DURENBERGER. Ms. Anderson, do you have a comment?

Ms. ANDERSON. Yes. We have tried to absorb the increased costs associated with increased CPI and charges of our contractors. I can only speak for Los Angeles County on this question, but our budget has increased about 8 percent last year, and we anticipate overall 4 to 6 percent this year; our budget is not finalized at this time.

However, the things that we did in order to absorb the cost, included not giving any of our employees a raise last year and not negotiating significant increases with our contractors.

But when we talk about the cost of services, the cost increases and for CCS, we have instituted a more controlled setting for treatment of our children, and we have also increased the case management and reduced some of the wide range of coverage that we had in the past. So as costs go up, our services are contracted.

Senator DURENBERGER. I am curious to know whether, particularly with hospital based service costs rising, we are seeing a utilization of alternative and less expensive but equally compassionate and an equal level of quality in terms of services? Are we seeing some imaginative uses of alternative settings for delivering some of these services?

Ms. ANDERSON. One of the things that has happened in California is that the State has given over to the counties the responsibility for the medically indigent person who does not qualify for the categorical programs and provided a specific dollar allocation for those services. The larger counties like Los Angeles, with hospitals and clinics, have set up special access programs designed to function something like prepaid health plans—not quite that yet, but sort of—and that has helped to allow us to provide services and helped to reduce the number of new persons going into the hospitals.

Senator DURENBERGER. Dr. MacQueen?

Dr. MACQUEEN. The CC directors applaud all efforts at cost containment.

Senator DURENBERGER. Well, one of them that I am trying to avoid, and obviously one of the reasons I care so much about reforming title XIX and helping to do a much better job—a totally better job—on the prevention side in all of these areas including title V is that my sense is that one of the ways to control the hospital costs or doctor costs is to pay every hospital only *X* number of dollars. And all that does is guarantee that every hospital, regardless of how good a job they do, is going to stay in existence. We are just going to bring everybody down to some level and pay them the same rate. And I don't really consider that "hospital cost containment."

But if you adopt my theory of hospital cost containment, which is based on consumer choice and competition, all of a sudden you find out you've got a large number of poor and a large dollar volume of medical education, and a whole lot of other things that we have been paying for in some other fashion the way we paid for rural telephone service out of our long distance rates, as an example.

It's an eye-opener to go to California and find out that three of the five teaching hospitals in California are broke because of the large volume of indigent care that the politicians have found no other place to provide for. We just heard about Mississippi here a little while ago, and it is happening all over the country But it is a problem that in my view needs to be dealt with explicitly, the way we are trying to deal with it here—deal with improving the way we provide access to health care for the economically disadvantaged, and stop categorizing them as "your medicaid," and "your elderly," and "your crippled," and "your" something else, you know, and "we've got a special program for you, depending on what category you fall into."

Basically there are people who are economically disadvantaged, either by age at one end or the other end of the spectrum or the basic economic incomes of life.

So I do appreciate your testimony and what I assume will be your cooperation with us as over the next few months we try to evolve a better national policy in the area of mothers and children. Thank you very much.

Our final panel, the hungry panel, will be Mr. Charles McGrew, director of the Bureau of Public Health Programs, from Arkansas; Mr. Daniel J. Gossert, director of the Family Health Services Division in Colorado; and Ms. Shirley Reed-Randolph, associate director of the Office of Health Services for the Illinois Department of Public Health.

Thank you for being here. I thank you for your patience. Your statements will be made part of the record, and you may proceed to summarize them.

STATEMENT OF CHARLES McGREW, DIRECTOR, BUREAU OF PUBLIC HEALTH PROGRAMS, ARKANSAS DEPARTMENT OF HEALTH, LITTLE ROCK, AR

Mr. **McGrew**. Mr. Chairman, my name is Charles McGrew. I am, as you know, director of the Bureau of Public Health Programs with the Arkansas Department of Health, the organizational unit that is responsible for all MCH programs that are operated by the State Health Department.

Organizationally, it might be worth noting that the local health units and the State Health Department are one organization in Arkansas, so when I allude to the services we provide, those also include at the county level the services that we provide.

In general, we are supportive of what the block grant has done in the way of flexibility, and we use that flexibility in an effort and initiative that we had already started, to look at better and more efficient ways to deliver services.

At the time the MCH block was implemented in Arkansas, the budget cuts necessitated that we go back and reprioritize everything that we were doing in the agency. And because we reprioritized that way, I think we approached the block grant very effectively in how we implemented it. Some of the things that we did are similar to those that were noted in the GAO report.

I think what probably has not been pointed out very well is that the State money that we came up with to continue what we were doing with maternal and child health came from other priority programs in the agency. We are a very poor State, and we don't have any programs that we operate that are not priority. We don't have enough money for anything that we are doing, really; so the money that we had to cut other places comes from areas that are also sorely in need.

Senator **Durenberger**. You just took money from somewhere else, you didn't raise taxes, did you?

Mr. **McGrew**. That is correct. Again, we are a poor State, and there has been a reluctance with the high level of unemployment for a tax increase, and I think that is certainly understandable on the part of the citizens of the State. The State is not being irresponsible in trying to address taking care of those people however they can. As a matter of fact, at this point there is an Indigent Care Committee that is looking at these very issues and will implement some changes in the next legislative session. So the State is taking responsibility; there just simply is not enough money, a combination of Federal and State dollars, to solve the problems.

At the time that we implemented the block grant, for instance, the medicaid program went through a 16-percent eligibility reduction, and we saw a 32-percent reduction in hospitalization paid for by the medicaid program. That program in Arkansas has been having problems for some time.

We also, on the State side, because of problems with weather—we have a lot of agriculture in Arkansas—and with the general recession, we saw an 8-percent decrease in our staff who are out there in the counties and in the central office providing services. At the same time that those two things were happening, along with the roughly 20-percent cut in the MCH block, hospital occupancy rates in Arkansas were beginning to get low enough so that hospitals were terribly concerned about their future. They were less likely to accept indigent patients, and of course we have seen that trend continue. That's one of the things that you just alluded to—What do you do, when you see cost containment and competition accomplish what we all hope it will, which is get people to look at what the money is being spent for?

One of the fallouts from that, obviously, is that they are going to be less likely to see people who don't have the funding source if you really turn the screws on what you can spend money for. And that's exactly what we are seeing. It is a terrible concern in our State. Again, we are a very poor State, where one out of every four children lives below the poverty line.

I think our experience with the Crippled Children's Program has been a little bit different from what you have seen in the GAO report, also. What we have seen in Arkansas, in fact, since Crippled Children's is located in the Department of Human Services and not in the Health Department and that same organization has the medicaid program and has a lot of funding problems, they did not see fit to shift funding from other areas to make up the deficit in the Crippled Children's Program. In fact, the cut was absorbed pretty much in the percentage that it came down to Crippled Children's in that particular program.

One of the things that I think you have heard testimony on on number of occasions in the past and again today is how cost-effective those dollars are. In your opening remarks you commented on wanting to see health care paid for rather than paying for taking care of acute conditions or illnesses, and in Arkansas the MCH dollars certainly go to health care, and those are the kinds of services we pay for.

The jobs bill money, which is absolutely critical for us to continue, for instance, funds one of the new initiatives in Delta County's—in eastern Arkansas along the Mississippi River. We funded two additional nurse-midwife programs in that area. There was one up toward the top of the area in partnership with community health centers, and we have a contract from a unique funding source, with the city of Memphis Hospital, to pay for high-risk maternity care. So, we are coming up with solutions that work and that are preventive, but there are simply not enough dollars there.

In the interest of time, I would like to conclude my comments. Thank you.

Senator **Durenberger**. I appreciate that summary very, very much.

Mr. Gossert?

[Mr. McGrew's written prepared statement follows:]

STATEMENT OF CHARLES MCGREW, MPH, DIRECTOR, BUREAU OF PUBLIC HEALTH PROGRAMS, ARKANSAS DEPARTMENT OF HEALTH

Mr. Chairman and Members of the Committee:

My name is Charles McGrew - I am the Director of the Bureau of Public Health Programs in the Arkansas Department of Health. As such I have responsibility for all public health service programs for women and children in the state.

We believe that we have been one of the more successful states in implementing the MCH Block Grant. One of the reasons I am here today is to talk to you about how we did this. However, I am also here to tell you that the 18% reduction in funds that accompanied the block grant could not, and cannot, be absorbed by improved program efficiency. For us these funds had to be drawn from other important agency programs, which suffered accordingly. There is a critical need to increase MCH Block Grant funding. In the developing entrepreneurial environment the needs for our services are expanding while the dollars are contracting.

At the same time that the OBRA funding cuts were being enacted, in Arkansas, where a quarter of all children live below the poverty level, other programs and services were also being cut.

- A shortfall in state funding resulted in an 8% reduction of the Health Department workforce.
- As a result of eligibility and program reductions, the number of Medicaid recipients declined 16% between January 1980 and January 1982 and hospital services declined 32%.

- The beginning of a substantial decline in hospital occupancy rates made hospitals more reluctant to serve the medically indigent population.
- physicians, too, are feeling increasing competitive pressures, and are less able to subsidize indigent patients.

Without an increase in funding for the MCH Block Grant, services for the more than 12,000 women served in the Health Department Maternity Program will be cut -- and 83% of these women are below the poverty line. I think you are all aware that a reduction in preventive and early primary care and delivery services to this group of women will cost both the State and Federal Government much more in the long run.

This is but one example of the overall cost savings and enhanced quality of life that can be realized by the efficient use of MCH dollars.

We do feel that the additional flexibility of the Block has been beneficial. The approach used by the Agency necessitated a reassessment of _all_ program expenditures, and resulted in a reduction of funding for some programs (i.e. Blood Lead, SIDS) and a shift of $400,000 from other state programs to MCH.)

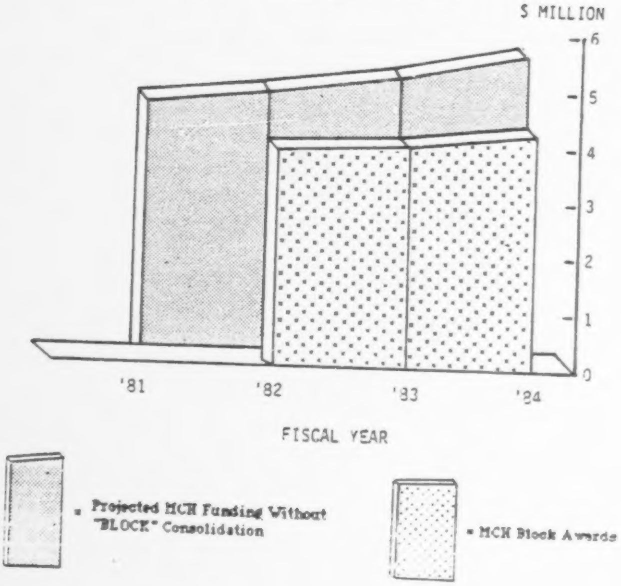
The purpose of this hearing, as I understand it, is to provide follow-up information to the GAO Report to Congress relative to implementation of the MCH Block Grant. Although Arkansas was not one of the thirteen (13) states reviewed in the GAO report, Arkansas' experience in implementing the MCH Block Grant was similar to the GAO's findings. Two of the areas have already been mentioned, but will be repeated for the sake of comparison.

1) Arkansas continued to support activities similar to those previously funded under the categorical programs, although some changes were made to the progam priorities and services offered,
2) the availability of concurrent categorical funded lessened the intital impact of the 18% cut in funds,
3) a supplementation of non-match state funds ($400,000) was provided to help offset the loss in funds for MCH,
4) the previously mandated Program of Projects were eliminated or reduced in scope in order to absorb a portion of the loss in federal support, and
5) funds for the Blood Lead Program were reduced by 50% and blood lead screenings were targeted to areas and populations at greatest risk. The result was that in FY81 12,170 children were screened and 181 identified with elevated lead levels as compared to 4,787 screened in FY83 and 116 identified elevated lead levels.

Emergency Jobs Bill funds for MCH were awarded in May, 1983 and available for FY'84 and resulted in expanded and improved Maternal and Child Health services. The attached graph does not include Emergency Jobs Bill funds, however, since such inclusion may be misleading for the following reasons:

1) the funds were to be used to expand services to a "new constituency" needing services as a result of high unemployment and increased demand and not to "restore" funds lost, and
2) the funds were intended to be one-time.

ARKANSAS
MATERNAL & CHILD HEALTH FUNDING*



	FY81 Formula Fund Categorical Award	MCH Block Grant Awards**		
		FY82	FY83	FY84
	$4,954,294	$4,132,734	$4,143,844	$4,432,691
MCH Funding (w/o Block Consolidation)***		$5,202,008	$5,462,108	$5,735,213
Funding Variances	-	$1,069,274 <20%>	$1,318,264 <24%>	$1,302,522 <23%>

* includes: MCH
SIDS
Blood Lead
CCS
SSI

**Does not include $1,372,350 Jobs Bill funds awarded 5/83 and available for FY'84.

***Continuing level amounts (with 5% allowance for inflation) that would have been awarded if programs had not been consolidated (and funds cut) into a block grant.

We recognize the need for states to assume responsibility for solving their indigent health care problems. Arkansas is making great efforts to develop new initiatives in this area. We also have to face the realities of the public health situation. Although the recession increased public health caseloads, the core MCH population served by state and local health departments will not disappear with an economic upswing. Our prime target populations come from the structurally unemployed, or under-employed. They are predominantly poor, single, female heads of households, their children, and poor teenagers.

As we enter an era of excess capacity in the health care industry, it is a sad irony that access to health services for the poor is as complex a problem as ever. In a competitive environment there is little financial slack in the system, and less willingness to subsidize health care for indigents. Furthermore, when serving the high risk, indigent client, public health agencies have a unique range of services that the private sector has not yet matched. Our strength lies in our preventive focus, our education programs, and our outreach. Our clients have critical needs for these services. Please help us to provide them to all who need them.

STATEMENT OF DANIEL J. GOSSERT, DIRECTOR, FAMILY HEALTH SERVICES DIVISION, COLORADO DEPARTMENT OF HEALTH, DENVER, CO

Mr. GOSSERT. Like Arkansas, Colorado has been pleased with the flexible format of the MCH block. It has allowed us to continue valuable services to mothers and children.

The legislation recognized State health departments' traditional role and expertise in health care and put the State in the position of being further able to integrate services at the point of delivery.

Colorado values integrated services, and the MCH activities are in the same unit as family planning, WIC, dental, and migrant health.

The block grant concept allows the State to assess its needs in the area of MCH and to set priorities based on the assessment that enables the State to target money to meet its own unique set of circumstances.

In administering the block, Colorado chose to take two major steps in developing a method for fund allocation. First, we established a Women and Children's Health Care Advisory Council, with 12 members representing State human service agencies—and, by the way, we do have good links with the title XIX agency in Colorado—human service agencies, private health care providers including physician groups and other professional groups, and we also have consumer representation on that advisory committee. The council meets monthly, and it is an open meeting.

The second thing that we did was set a two-stage process to evaluate requests for use of MCH funds, and this process includes evaluations of past performance on programs that continue to receive MCH money. Applications are open to any provider of service who can meet the criteria, although we do give preference to local health departments.

In the first year of the block we did set a comprehensive set of goals and objectives, stressing prevention, and that was in cooperation with our advisory committee. And we have been able to some extent to change priorities to meet changing needs. The process has allowed us to place less emphasis on children and youth and maternal and infant comprehensive service and to place more emphasis on adolescent health needs, and to extend coverage to low-income prenatal women across most of Colorado.

The flexibility of the block also allowed Colorado to cope with reduced funding for services, although demand remains high.

As a matter of fact, in the past 2 years Colorado has had diminished State revenues and diminished revenues available for maternal and child health activities. At the same time, demand for services has risen and inflation has taken a significant toll. As a consequence, Colorado has not been able to fund services at an adequate level, and we have had service reductions.

Two examples of service reductions: In our handicapped children's program, or crippled children's program, because primarily of the inflation, because those funds have not been cut at the State level, we are serving 300 fewer children, from 5,200 down to 4,900 children for paid service or clinic service, simply because the costs have gone up.

In Colorado, hospital costs over the last 4 years—this is from Blue Cross/Blue Shield who does audits for themselves, title XIX, medicare and ourselves—those costs have run from a low of 12.8 percent, the lowest figure, to 1 year inpatient costs running over 17 percent per year.

One alternative we have done, in particular in our handicapped children's program, is to stress the use of outpatient surgery facilities wherever that is feasible.

Thank you.

Senator **Durenberger**. And that's not—I say this from some little knowledge, having visited there a year or so ago—it is not because the Governor, the legislature, and private foundations in Colorado are not dealing with the problem of economically-disadvantaged in its various components.

My impression is that there is a strong commitment in the State of Colorado to dealing with these problems, and when the statistics drop it doesn't strike me to be an insensitivity on the part of Coloradans to the problems.

Mr. GOSSERT. I think that is in part true. The Peton Foundation in Colorado recently did a study of medically indigent in Colorado and found, I believe, that their modest proposal—which really wouldn't get into some of the needs that I have been talking about—that Colorado would have to pump in about $7 million to $8 million more into their medically indigent program to just serve 100 or 150 percent of poverty level folks.

I think the Governor has been very, very concerned about that; I can't say the same for the State legislature, because in 1983, in response to diminished revenues, they trimmed our budget for maternal and child health by $1.2 million.

Senator DURENBERGER. Thank you for clarifying that.

Ms. Randolph?

[Mr. Gossert's preapared statement follows:]

COLORADO'S EXPERIENCE
WITH THE
MATERNAL AND CHILD HEALTH BLOCK GRANT

JUNE 15, 1984
FAMILY HEALTH SERVICES DIVISION
COLORADO DEPARTMENT OF HEALTH
4210 EAST 11TH AVENUE
DENVER, COLORADO 80220

I. BLOCK GRANT CONCEPT

THE BLOCK GRANT CONCEPT ALLOWS THE STATE OF COLORADO AUTHORITY, FLEXIBILITY, AND RESPONSIBILITY. TO THAT END, THE STATE CAN ASSESS THE NEED FOR MATERNAL AND CHILD HEALTH CARE ACROSS THE STATE, IT CAN SET ITS OWN PRIORITIES AS TO PROGRAMS OR GEOGRAPHICAL AREAS, AND IT CAN MONITOR PROJECTS MORE EASILY BECAUSE IT IS DEALING WITH THEM ON A REGULAR AND FREQUENT BASIS.

A. ASSESS STATE'S NEEDS

THE STATE OF COLORADO HAS DEVELOPED A NEED MEASURE FOR MATERNAL AND CHILD HEALTH. IT IS BASED ON BOTH THE SIZE OF A PROBLEM (MEASURED IN NUMBERS) AND THE INTENSITY OF A PROBLEM (MEASURED BY RATES). IT USES THE CHILDREN, ADOLESCENTS AND WOMEN OF CHILDBEARING AGE (NUMBERS AND PERCENTAGES OF POPULATION). IT USES BIRTHS (NUMBERS AND RATES), LOW BIRTH WEIGHT INFANTS (NUMBERS AND RATES), AND INFANT MORTALITY RATES. THE NEED MEASURE IS ALSO HEAVILY WEIGHTED FOR INCOME USING 1980 CENSUS DATA ON ACTUAL MEDIAN HOUSEHOLD INCOME, AND PERCENTAGES OF HOUSEHOLDS AT THE LOWER END OF THE INCOME DISTRIBUTION. THE MEASURE ALSO USES THE NUMBER OF AFDC CASES AND THE POPULATION PER PRIMARY CARE M.D. RATIO.

EACH COUNTY RECEIVES A RATING AND THE RATINGS ARE GROUPED INTO FOUR LEVELS OF NEED. A COUNTY WHICH HAS A LARGE POPULATION, HIGH LOW BIRTH WEIGHT RATES, HIGH INFANT MORTALITY RATES, AND A LOW MEDIAN INCOME, FOR EXAMPLE, WOULD RATE VERY HIGH ON THE SCALE.

APPLICATIONS FROM COUNTIES IN THE HIGHEST NEED AREAS ARE LIKELY TO BE APPROVED IF THEY MEET OTHER REVIEW CRITERIA; APPLICATIONS FROM COUNTIES IN THE LOWEST NEED AREAS ARE MUCH LESS LIKELY TO BE APPROVED EVEN IF THEY MEET THE OTHER REVIEW CRITERIA. NINE OUT OF TEN AWARDS WHICH ARE LOCAL AND NOT STATEWIDE PROGRAMS ARE FROM COUNTIES WITH THE TWO HIGHEST NEED LEVELS; ONE IS FROM THE NEXT NEED LEVEL, AND THERE ARE VIRTUALLY NONE IN THE LOWEST NEED RATING.

B. SET STATE'S PRIORITIES

IN 1981, A STATE TASK FORCE ON ADOLESCENTS DESCRIBED NEED FOR

ADOLESCENT HEALTH CARE ON A VARIETY OF ISSUES (E.G., TEEN PREGNANCY), AND URGED STATE COMMITMENT TO FUNDING. COLORADO HAS GONE FROM NO DOLLARS IN SPECIFIC ADOLESCENT CARE PROJECTS TO ABOUT 5% OF DOLLARS FROM THE MCH BLOCK GRANT.

PRENATAL CARE FOR LOW INCOME WOMEN HAS ALSO BEEN TARGETED AS AN AREA NEEDING EXPANSION, AND COLORADO HAS DOUBLED THE COMMITMENT BETWEEN 1981-82 AND 1983-84, FROM 12.5% TO 25% OF THE MCH BLOCK.

THUS, THE STATE OF COLORADO USES THE BLOCK TO ADDRESS NEEDS ACCORDING TO GEOGRAPHIC AREA AND, ALSO, ACCORDING TO TYPE OF PROGRAM. THIS HAS GIVEN THE STATE AUTHORITY TO DETERMINE WHAT TAKES PLACE WITH THE MCH BLOCK GRANT AND THE FLEXIBILITY TO USE THE FUNDS IN WAYS WHICH MEET THE PRIORITIES OF THE STATE HEALTH DEPARTMENT.

C. MONITOR PROJECTS

THE STATE IS IN A POSITION TO MONITOR CLOSELY EACH PROJECT WHICH RECEIVES BLOCK GRANT FUNDS. COLORADO REQUIRES A PROGRESS REPORT IN MAY ON THE FIRST SIX MONTHS OF THE FEDERAL FISCAL YEAR. HOW WELL A PROJECT IS DOING OBVIOUSLY HAS AN IMPACT ON HOW ITS NEXT YEAR'S REQUEST IS VIEWED. AN ANNUAL REPORT IS ALSO REQUIRED AT THE CLOSE OF THE FISCAL YEAR, WHICH ALSO ALLOWS EVALUATION OF HOW WELL EACH PROJECT HAS MET ITS OBJECTIVES.

THE STATE HEALTH DEPARTMENT HAS CONDUCTED INTENSIVE SITE EVALUATIONS AND CHART AUDITS WHICH RESULTED IN NUMEROUS RECOMMENDATIONS AND LED TO MANY IMPROVEMENTS IN THE LAST YEAR. THESE WERE DONE WITH THE CHILDREN AND YOUTH AND MATERNITY AND INFANT PROJECTS, WHICH UTILIZE THREE TO FOUR OUT OF EVERY TEN MCH BLOCK GRANT DOLLARS.

THESE ACTIVITIES DEMONSTRATE HOW THE STATE ASSUMES RESPONSIBILITY FOR HOW THE MCH BLOCK GRANT FUNDS ARE USED EACH YEAR.

II. STATE'S ABILITY TO ADMINISTER MCH BLOCK

THE STATE OF COLORADO HAS DEVELOPED A FAIR WAY TO USE THE BLOCK FUNDS, AS FOLLOWS:

A. ADVISORY COUNCIL

AN ADVISORY COUNCIL WAS ESTABLISHED WHEN THE BLOCK GRANT WAS FIRST RECEIVED. THE ADVISORY COUNCIL EVALUATES THE HEALTH NEEDS OF WOMEN AND CHILDREN IN THE STATE, RECOMMENDS PRIORITIES FOR SERVICES, AND SERVES AS AN ADVOCATE FOR WOMEN AND CHILDREN'S HEALTH CARE IN THE STATE.

THE ADVISORY COUNCIL IS MADE UP OF REPRESENTATIVES FROM THE COLORADO CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, THE COLORADO MEDICAL SOCIETY, THE COLORADO PERINATAL COUNCIL, THE CHILD HEALTH COUNCIL, THE COLORADO ACADEMY OF FAMILY PHYSICIANS, THE COLORADO CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, THE COUNTY NURSES ASSOCIATION, REPRESENTATIVES FROM THE STATE DEPARTMENT OF SOCIAL SERVICES, THE STATE DEPARTMENT OF EDUCATION, THE STATE DEPARTMENT OF INSTITUTIONS, THE COLORADO HEALTH AND ENVIRONMENT COUNCIL, THE GOVERNOR'S COMMISSION ON FAMILY AND CHILDREN, AND THE ADOLESCENT HEALTH COUNCIL. THE ADVISORY COUNCIL MEETS MONTHLY AND HAS A HIGH LEVEL OF INPUT. MEMBERS PARTICIPATE IN THE GRANT REVIEW PROCESS AND ARE ACTIVE IN MAKING RECOMMENDATIONS THROUGHOUT THE YEAR. THE COUNCIL PLAYS A VERY IMPORTANT ROLE IN SETTING STATE PRIORITIES FOR USE OF THE BLOCK GRANT FUNDS.

B. TWO-STAGE APPLICATION PROCESS

THE FAMILY HEALTH SERVICES DIVISION OF THE COLORADO DEPARTMENT OF HEALTH HAS ESTABLISHED A TWO-STAGE PROCESS FOR EVALUATING APPLICATIONS FOR USE OF THE BLOCK GRANT. THIS PROCESS IS OPEN AND WELL KNOWN AMONG HEALTH CARE PROVIDERS ACROSS THE STATE. WORKSHOPS ARE PROVIDED IN DIFFERENT LOCATIONS EACH SPRING AND APPLICANTS ARE ASSISTED

IN FINDING THE DATA THEY NEED FOR THEIR GRANTS AND IN ANY OTHER AREAS FOR WHICH THEY NEED TECHNICAL ASSISTANCE.

THE REVIEW CRITERIA ARE SENT OUT WITH THE APPLICATION MATERIAL SO THAT EACH APPLICANT IS AWARE OF HOW ITS APPLICATION WILL BE REVIEWED.

IN THE FIRST STAGE, EMPHASIS IS ON APPROPRIATENESS OF THE APPLICATION FOR MCH BLOCK FUNDING ACCORDING TO THE FEDERAL LEGISLATION, ACCORDING TO THE STATE OF COLORADO BLOCK GRANT GOALS, AND THE STATE'S CURRENT PRIORITY AREAS (WHICH ARE CURRENTLY TOWARD PRENATAL AND ADOLESCENT PROGRAMS AND AWAY FROM COMPREHENSIVE CARE PROGRAMS). EMPHASIS IS ALSO ON DIRECT SERVICE PROGRAMS, NON-DUPLICATION OF SERVICE IN GEOGRAPHIC AREAS, CONTINUING AS OPPOSED TO NEW PROJECTS, DIRECT IMPACT ON A LARGE NUMBER RATHER THAN A SMALL NUMBER OF WOMEN AND CHILDREN, LOW COST PER CLIENT, AND ABILITY OF THE APPLICANT TO SECURE OTHER SOURCES OF FUNDING, AS WELL. A TEN PERSON REVIEW PANEL MADE UP OF HEALTH DEPARTMENT STAFF AND AN ADVISORY COUNCIL REPRESENTATIVE REVIEWS EACH APPLICATION FOR HOW WELL THESE CRITERIA ARE MET.

AFTER STAGE I, ABOUT HALF OF THE NEW APPLICANTS ARE ELIMINATED. APPLICATIONS ARE USUALLY ELIMINATED BECAUSE THEY MAY BE ONLY PARTIALLY RELATED TO THE FEDERAL LEGISLATION, ARE RELATIVELY HIGH COST, SERVE RELATIVELY FEW PATIENTS, AND DO NOT SECURE PARTIAL FUNDING FROM OTHER SOURCES. THIS RIGOROUS REVIEW IS NECESSARY AS FUNDS ARE NOT ADEQUATE TO MEET THE NEEDS OF THE MCH TARGET POPULATION.

STAGE II REQUIRES A TEN TO FIFTEEN PAGE, SINGLE-SPACED APPLICATION CONTAINING A WELL DOCUMENTED STATEMENT OF NEED, A CLEAR DESCRIPTION OF PROJECT ADMINISTRATION, MEASURABLE, SPECIFIC AND TIME-FRAMED OBJECTIVES, A LOGICAL AND PROVEN PROGRAM RATIONALE, A DETAILED WORKPLAN FOR THE

12-MONTH PERIOD, A DESCRIPTION OF THE PROFESSIONAL STAFF TO BE USED, A MONITORING AND EVALUATION PLAN, AND A DETAILED BUDGET INCLUDING WRITTEN JUSTIFICATION OF EACH MAJOR LINE ITEM. EACH SECTION IS SCORED BY TWO REVIEWERS FROM A FIFTEEN PERSON REVIEW PANEL WHICH DISCUSSES EACH APPLICATION DURING A THREE DAY REVIEW HELD IN JULY. EACH APPLICANT HAS THE OPPORTUNITY TO ATTEND PART OF ITS REVIEW AND TO EXPLAIN ITS PROJECT TO THE REVIEW PANEL. THE PANEL IS MADE UP OF HEALTH DEPARTMENT STAFF AND ADVISORY COUNCIL MEMBERS.

IN THE SECOND STAGE, THE REVIEWERS ARE CONCERNED WITH HOW WELL THE APPLICATION ADDRESSES THE NEED OF A PARTICULAR GEOGRAPHIC AREA OR PROBLEM WHICH IS A PRIORITY, HOW WELL THE WORK PLAN FITS WITH THE OBJECTIVES OF THE APPLICATION, HOW LIKELY THE OBJECTIVES ARE TO BE MET (AND HERE, IT REFERS TO THE REQUIRED PROGRESS REPORTS ON PAST PERFORMANCE), AND HOW APPROPRIATE THE STAFF AND BUDGET ARE.

PROJECTS ARE RANKED FROM HIGH TO LOW BY THE REVIEW PANEL AND THE FUNDING IS AWARDED TO THE HIGHEST RATED PROJECTS FIRST. WHEN FUNDING IS INADEQUATE, LOW RATED PROJECTS ARE NOT APPROVED AND FUNDS ARE REDUCED IN CONTINUING PROJECTS TO FIT FUND AVAILABILITY.

AFTER STAGE II, CONTRACTS ARE WRITTEN WITH EACH APPLICANT AND THE STATE THEN TRACKS ITS EXPENDITURES AND FOLLOWS ITS PERFORMANCE.

III. STATE PRIORITY SETTING

IN 1982, THE COLORADO DEPARTMENT OF HEALTH WROTE ITS GOALS FOR USE OF THE MCH BLOCK GRANT FUNDS. THESE GOALS EMPHASIZE PROTECTING AND IMPROVING THE HEALTH OF THE PEOPLE OF COLORADO BY ENHANCING THE ACCESS OF CHILDREN, MOTHERS AND PREGNANT WOMEN TO HEALTH CARE SERVICES. EACH YEAR SINCE THEN, HEALTH DEPARTMENT STAFF AND THE ADVISORY COUNCIL HAVE REVIEWED THE SPECIFIC AREAS CONTAINED IN THE OVERALL GOALS AND HAVE CHOSEN SOME TO EMPHASIZE IN THAT YEAR.

SINCE THE ESTABLISHMENT OF A BLOCK GRANT, THERE HAVE NOT BEEN ADEQUATE FUNDS TO FULFILL ALL THE HEALTH DEPARTMENT GOALS. THUS, CERTAIN AREAS RECEIVE MORE ATTENTION AT THE EXPENSE OF OTHERS EACH YEAR. FUNDING FOR DIRECT SERVICES HAS BEEN MORE EMPHASIZED THAN THE PROVISION OF TECHNICAL ASSISTANCE BY HEALTH DEPARTMENT STAFF TO LOCAL PROGRAMS, FOR EXAMPLE.

THE ABILITY TO FOCUS ON CHANGING AREAS OF NEED, HOWEVER, HAS BEEN VERY POSITIVE FOR THE STATE. AS DESCRIBED ABOVE UNDER SECTION I, IN THE LAST THREE YEARS, THE STATE HAS SHIFTED FROM OVER FOUR OUT OF EVERY TEN DOLLARS BEING SPENT ON COMPREHENSIVE CHILDREN AND YOUTH SERVICES TO LESS THAN THREE DOLLARS. AT THIS SAME TIME, THE STATE HAS INCREASED SPENDING ON ADOLESCENT PROGRAMS AND PRENATAL AND MATERNITY PROGRAMS. THESE CHANGES HAVE BEEN MADE ADHERING TO THE POLICY OF MOVING AWAY FROM COMPREHENSIVE CARE TOWARD PREVENTIVE CARE.

IV. STATE MATCH

THE BLOCK CALLS FOR A $3 MATCH FOR EVERY 4 FEDERAL DOLLARS EXPENDED. THE MATCH IS FLEXIBLE AND CAN BE EITHER DIRECTLY APPROPRIATED FUNDS FROM THE LEGISLATURE, CASH FUNDS THAT ARE GENERATED FROM USER FEES, OR LOCAL HEALTH DEPARTMENT SUPPORT.

V. ADEQUACY OF FUNDING

THE LEVEL OF FUNDING FOR THE STATE OF COLORADO HAS NOT BEEN COMMENSURATE WITH THE SIZE OF REQUEST FOR FUNDS FOR MERITORIOUS PROGRAMS TO PROVIDE NEEDED SERVICES. LAST YEAR, FOR FISCAL 1983-84, THE STATE RECEIVED 38 REQUESTS TOTALING $7,000,000. FUNDING AVAILABILITY LIMITED THE AWARDS TO 27 APPLICATIONS TOTALING $5,000,000. THESE AWARDS INCLUDE THE ONE-TIME JOBS BILL MONEY. THE SHORTFALL WAS NEVERTHELESS $2,000,000.

THIS YEAR, FOR FISCAL 1984-85, THE STATE HAS RECEIVED 41 REQUESTS TOTALING $6,340,000. (THIS DROP FROM LAST YEAR'S REQUESTS WAS MADE WITH KNOWLEDGE BY THE APPLICANTS THAT THERE WOULD BE LESS DOLLARS AVAILABLE THAN LAST YEAR.) PROJECTED BLOCK GRANT REVENUES AT THIS WRITING AMOUNT TO APPROXIMATELY $4,300,000, YIELDING A SHORTFALL AGAIN OF OVER $2,000,000 (ATTACHMENT B).

AS AN EXAMPLE OF LIMITS ON SERVICES, PLEASE REFER TO THE ATTACHED CHART SHOWING A DOWNWARD TREND IN THE ABILITY OF HANDICAPPED CHILDREN'S PROGRAM TO MAINTAIN SERVICES TO ITS TARGET POPULATION (ATTACHMENT C).

COLORADO DEPARTMENT OF HEALTH

Richard D. Lamm
Governor

Thomas M. Vernon, M.D.
Acting Executive Director

MARCH 1, 1984

THE COLORADO DEPARTMENT OF HEALTH FAMILY HEALTH SERVICES DIVISION IS NOW BEGINNING ITS CONSIDERATION OF APPLICATIONS FOR THE TITLE V MATERNAL AND CHILD HEALTH BLOCK GRANT FOR THE FISCAL YEAR OCTOBER 1, 1984 - SEPTEMBER 30, 1985. IF YOUR AGENCY WISHES TO AGAIN APPLY FOR MCH BLOCK GRANT FUNDS, PLEASE REVIEW THE ENCLOSED MATERIALS CAREFULLY.

THE APPLICATION PACKET CONTAINS:

1. STAGE I APPLICATION FORMAT
2. STAGE I CRITERIA
3. STAGE II APPLICATION FORMAT, TITLE PAGE, BUDGET PAGES, WORK PLAN PAGE
4. STAGE II CRITERIA
5. SIX-MONTH PROGRESS REPORT OUTLINE, OCTOBER 1983-MARCH 1984.

THERE ARE FEW CHANGES FROM LAST YEAR'S PROCESS; HOWEVER, THE SCHEDULE AND SOME OF THE REQUIREMENTS ARE DIFFERENT.

THE APPLICATION PROCESS WILL AGAIN BE COVERED IN TWO STAGES:

1. STAGE I - A BRIEF NOTIFICATION OF INTENT (FOLLOWING THE STAGE I APPLICATION FORMAT ENCLOSED), WHICH WILL BE REVIEWED ACCORDING TO THE STAGE I CRITERIA. SOME APPLICATIONS MAY NOT BE APPROVED FOR CONTINUATION TO STAGE II AND WILL DROP OUT OF THE GROUP OF APPLICANTS. OTHERS WILL RECEIVE APPROVAL TO PROCEED TO STAGE II.

2. STAGE II - A FULL APPLICATION (FOLLOWING THE STAGE II APPLICATION FORMAT). STAGE II APPLICATIONS WILL BE REVIEWED ACCORDING TO STAGE II CRITERIA. SOME APPLICATIONS MAY NOT BE APPROVED, SOME MAY BE RECOMMENDED FOR LESS THAN THE REQUESTED FUNDS, AND SOME MAY BE FUNDED AT THE FULL REQUESTED AMOUNT.

THE SCHEDULE FOR THE APPLICATION PROCESS IS AS FOLLOWS:

1984	APPLICATION PROCESS
APRIL 9, 5 P.M.	6 COPIES OF STAGE I APPLICATION DUE IN FAMILY HEALTH SERVICES DIVISION OFFICE
MAY 15, 5 P.M.	6 COPIES OF SIX-MONTH PROGRESS REPORT (OCTOBER 1983-MARCH 1984) DUE IN FAMILY HEALTH SERVICES DIVISION OFFICE
MAY 25	RESULTS OF STAGE I REVIEW WILL BE MAILED TO APPLICANTS
JULY 2, 5 P.M.	6 COPIES OF STAGE II APPLICATION DUE IN FAMILY HEALTH SERVICES DIVISION OFFICE
SEPTEMBER 1	NOTIFICATION TO APPLICANTS REGARDING RESULTS OF STAGE II AND FINAL FUNDING DECISIONS
OCTOBER 1	EFFECTIVE DATE OF 12-MONTH CONTRACT FOR FY 84-85.

APPLICATIONS WHICH ARE TURNED IN AFTER THE DEADLINES WILL BE ELIMINATED FROM THE REVIEWS.

IF YOU WOULD LIKE A COPY OF A STAGE II APPLICATION WHICH RECEIVED A HIGH RATING LAST YEAR, PLEASE CONTACT BILLIE NOEL IN THIS OFFICE, AT 320-6137, EXTENSION 430. YOU MAY ALSO ASK FOR COPIES OF THE BLOCK GRANT LEGISLATION AND THE DIVISION GOALS (SENT TO YOU LAST YEAR).

A FEW CHANGES HAVE BEEN MADE IN THE REQUIREMENTS FROM LAST YEAR. THE STAGE I APPLICATION MAY AGAIN OMIT A DESCRIPTION OF THE NEED FOR THE PROJECT (A), THE GOALS OF THE PROJECT (B), AND THE AGENCY (F), IF THERE ARE NO SIGNIFICANT CHANGES FROM FY 83-84. IF, HOWEVER, THERE ARE CHANGES, THEY SHOULD BE DESCRIBED.

THE STAGE II APPLICATION FORMAT IS BASICALLY THE SAME, BUT YOU MAY NOT HAVE TO ANSWER ALL THE QUESTIONS AGAIN. THE TITLE PAGE FOR STAGE II, WHICH IS ENCLOSED AND MARKED FOR YOUR PROGRAM, LISTS:

1. THE QUESTIONS WHICH YOU MUST ANSWER, AND
2. THE QUESTIONS FOR WHICH YOU MAY ATTACH LAST YEAR'S ANSWERS.

QUESTIONS SHOWN UNDER 2., PRECEEDING PAGE, WERE RATED VERY FAVORABLY BY LAST YEAR'S REVIEW COMMITTEE. IF THERE ARE ANY SIGNIFICANT CHANGES, YOU MUST DESCRIBE THEM IN ADDITION TO SUBMITTING LAST YEAR'S ANSWERS. YOU MAY ALSO REWRITE THEM ENTIRELY, IF YOU WISH. (WE ARE ASKING YOU TO SUBMIT LAST YEAR'S ANSWERS FOR THE USE OF REVIEWERS WHO NEED TO UNDERSTAND YOUR PROJECT IN ITS ENTIRETY.) OF COURSE, MOST ANSWERS HAVE TO BE REWRITTEN REGARDLESS OF HOW WELL THEY WERE DONE LAST YEAR BECAUSE THEY PERTAIN TO A NEW FISCAL YEAR (E.G., THE GOALS AND OBJECTIVES, WORK PLAN, BUDGET).

WE ENCOURAGE APPLICATIONS TO INCLUDE AN INCREASED PROPORTION OR AMOUNT, OVER LAST YEAR, OF DOLLARS FROM OTHER SOURCES, OR TO INCLUDE INCREASED PROPORTIONAL AMOUNTS OF IN-KIND CONTRIBUTIONS. HOWVER, CIRCUMSTANCES UNIQUE TO EACH KIND OF PROJECT WILL BE TAKEN INTO CONSIDERATION IN ASSESSING THESE EFFORTS.

THE SIX-MONTH PROGRESS REPORT IS DUE ON MAY 15TH THIS YEAR. IT SHOULD COVER THE PERIOD OF OCTOBER 1983-MARCH 1984 AND SHOULD FOLLOW THE FORMAT OF THE ENCLOSED OUTLINE.

AS MANY OF YOU ARE AWARE, MOST PRENATAL APPLICATIONS WILL BE CONSOLIDATED AGAIN THIS YEAR INTO ONE APPLICATION. THE EXCEPTIONS ARE THE UCHSC PROGRAMS AND THE TRI-COUNTY M&I PROJECT. CHECK WITH SALLY BEATTY, 320-6137, EXTENSION 307, IF YOU ARE UNSURE WHAT YOU SHOULD DO.

WE HOPE THESE CHANGES WILL MAKE THE GRANT WRITING PROCESS A LITTLE EASIER THIS YEAR. IF YOU HAVE ANY QUESTIONS, PLEASE CALL.

WE LOOK FORWARD TO RECEIVING YOUR STAGE I APPLICATION BY APRIL 9TH.

YOURS VERY TRULY,

DANIEL J. GOSSERT, ACSW, M.P.H.
DIRECTOR,
FAMILY HEALTH SERVICES DIVISION

DJG:BN
ENCLOSURES

ATTACHMENT B

COLORADO

MATERNAL AND CHILD HEALTH BLOCK GRANT

REQUESTS AND AWARDS

1983-84 AND 1984-85

FISCAL YEAR	NUMBER OF REQUESTS	AMOUNT OF REQUESTS (IN MILLIONS)	NUMBER OF AWARDS	AMOUNT OF AWARDS (IN MILLIONS)	SHORTFALL (IN MILLIONS)
1983-84	38	$7.0	27	$5.0	$2.0
1984-85	41	$6.3	25-33*	$4.3**	$2.0

* TO BE DECIDED JULY, 1984

** PROJECTION

6/11/84

ATTACHMENT C

SERVICES PROVIDED TO COLORADO CHILDREN
BY HANDICAPPED CHILDREN'S PROGRAM

NUMBER RECEIVING PAID SERVICE

80/81	81/82	82/83
3710	3293	3221

UNDUPLICATED NUMBER SERVED
(CLINIC AND PAID SERVICES)

5220	5101	4933

STATEMENT OF SHIRLEY F. REED-RANDOLPH, ASSOCIATE DIRECTOR, OFFICE OF HEALTH SERVICES, ILLINOIS DEPARTMENT OF PUBLIC HEALTH, SPRINGFIELD, IL

Ms. **Randolph**. Thank you, Senator.

On behalf of the State of Illinois I would like to say thank you for inviting us to participate in this oversight hearing and for giving us the opportunity to discuss our experiences with the MCH block grant.

In my role as associate director of the department I am responsible for the administration of that block grant, as well as another one, and I have had experience with the block grant as well as with the former categorically-funded programs.

I will summarize my statement, since you have a written document, and try to hit what we think are the highlights.

One of the changes that Illinois would like to see made in terms of the MCH block grant is in the method in which the funds are distributed to the States. We feel that some reconsideration should be given to the formula funding that has been in existence for quite some time.

We know that in 1982 the Secretary of HHS reported to the Congress and at that time made no recommendations for changes because of some new Federal initiatives that may or may not become fruitful. Well, they never have come to fruition, and we think perhaps it's time now to look at that formula funding again and to put the Federal dollars where the people in need are.

Illinois has the distinct misfortune of having one of the highest infant mortality rates in the Nation. Our infant mortality rate for the fiscal year 1982 was 13.6 per 1,000 live births, down only about 0.3 percent from the previous year.

In the city of Chicago we have 18.6 infant deaths for every 1,000 live births, and among those nonwhite, it soars to 24.8 per 1,000 live births—more than double the national average, based on 1982 provisional figures of 11.2, per 1,000.

So, we feel that some consideration should be given to putting the funds where the problems are—where there are large numbers of children living in poverty, where there is a high infant mortality rate, where there is a high incidence of low birth weight—and we would urge you to recommend to the Secretary of HHS that we once again reopen the issue of formula funding.

I can understand very clearly on a personal basis what it means to talk about changing a formula; I have been down that road. In the State of Illinois we have a formula funding process for our local health departments, and I know it is not easy to make changes—it is very, very difficult.

We finally implemented such a formula for distribution of State general revenue funds, and it has been in existence for about 4 years. I think it has gained acceptance.

Perhaps the time to institute changes in the formula is the fiscal year coming up, when we probably are going to have additional dollars to distribute, and any cuts would be, therefore, minimized.

Perhaps another thing to look at is spreading out the changes in the formula funding over a period of 2 to 3 years, so that it equals out a little bit and no one is hurt drastically at the beginning.

One of the other things I would like to comment on briefly—you asked a number of individuals about savings in administrative costs. I can't give you a dollar figure from Illinois 'experience; but I can tell you, in terms of the block grants, that we spend far less time writing reports and filling out forms and answering grant conditions, and we spen more time trying to develop programs.

Senator DURENBERGER. Would you clarify that for me?

Ms. RANDOLPH. Yes; I would.

Let me skip to another part of my testimony. We have developed several initiatives in the State of Illinois that we think have done something different with the block grants. The first thing that we did in the first year of block grants was to make some of those funds available all across the State to all of our local health departments. Up to that point in time, only a handful had ever participated in the MCH federally funded programs.

We looked at what was happening, and we said why not give our local health departments the options and the same kinds of flexibility that we have gotten at the State level. And we dedicated a small portion, to be sure—but we did start—to allow local agencies to tell us, within the rubric of what maternal and child health services are, what their priorities for block grant funding would be, and to write an application and receive those funds. As a result, we have 87 local agencies who now participate in the MCH block grant.

Most of these services at the local level are going to provide additional services for adolescents and for high-risk mothers. And we are very proud that we have been able to start that.

Another initiative that we have spent some time developing has to do with the transferability of the blocks. We took funds out of the social services block grant, transferred it to the maternal and child health block grant, used those moneys to purchase immunizing agents, and the State health department distributes those to physicians to use in immunizing medicaid kids instead of charging the medicaid program. We have the advantage of using the Federal contracts that the State health department has, and taking those funds and buying at a much less cost than the private physicians or the private clinics would be expending. And by taking this action, the State, it is estimated, will save from a half to a million dollars per annum, just on that one use of the transferability of the blocks.

The third program that we are most proud of, that was developed and announced by Gov. Jim Thompson about a year ago, is the Parents Too Soon Program, which is a program dedicated to looking at what we can do about the dreadful problem of teenage pregnancy in our State. Fourteen percent of all of our live births are to teens. We had 44,900 teen pregnancies in our State in 1982. Of that number, 43 percent either had a spontaneous abortion or an induced abortion. We have 150,000 infants and preschoolers living with 130,000 teen parents, two-thirds of whom are under the age of 17, 80 percent of whom are unmarried, and 80 percent of whom had unintended pregnancies. Teen pregnancy is one of the major problems in our State in terms of social and health and educational and economic issues. Governor Thompson used the flexibility of the blocks and the addition of the supplemental jobs bill funding and developed a program that we hope will help deal with the problems of adolescent pregnancy.

The other point I would like to make before concluding that we would urge you not just to raise the ocean higher—we would like to see that $478 million in the allocation appropriated to the States—we certainly would direct more of our funds into the problems of adolescent pregnancy if we had additional funding, but we would also urge you not only to make the ocean higher, but to redirect the way the ocean flows, so that the maldistribution of funds that currently exists can be dealt with through a formal change as a result of congressional policy. And we thank you very much.

Senator **Durenberger**. Thank you very much.

On that last program you are proud of, I want to share with you the fact that the Republican Party in Minnesota has what they think is an even better program that they just put through our platform committee, and that is they are going to stamp out premarital sex; they are going to stop teaching sex eduction, and then they are going to have prayer in the schools. And that sounds to me like a much less expensive way to handle this problem. [Laughter.]

Ms. **Randolph**. It may be less expensive, but I bet it will be less effective.

Senator **Durenberger**. You've got it.

[Ms. Randolph's written prepared testimony follows:]

TESTIMONY FOR THE HEALTH SUBCOMMITTEE, SENATE FINANCE COMMITTEE
OVERSIGHT HEARING ON THE MCH BLOCK GRANT, June 20, 1984
Presented By
Shirley F. Reed-Randolph, MSPH, Associate Director
Illinois Department of Public Health

Mr. Chairman and Members of the Health Subcommittee:

Thank you for your invitation to speak to the issue of the Maternal and Child Health Block Grant; in particular how this shift in administering federal programs from categorical grants to the flexibility of block grants has worked in Illinois...how we have utilized this approach and what we have accomplished as a result of the federal initiative implemented under the Omnibus Budget Reconciliation Act of 1981.

Since December of 1979, I have served as the Associate Director for the Office of Health Services, Illinois Department of Public Health. Prior to that I served as the Assistant Associate Director for four years. The Department's Maternal and Child Health Program is administered within the rubric of the Office of Health Services, so I have had personal experience with both the categorical approach to the Maternal and Child Health Program as well as with the block grant alternative.

Reaction/Comment on GAO Report

I wish to commend the members of this Subcommittee for having this oversight hearing on the Maternal and Child Health Block Grant in order to hear first-hand from the States our reactions to this approach to federal funding. In general, the Illinois experience with the MCH Block Grant is similar to that of the 13 states reviewed by U.S. General Accounting Office as described in the May 7 Report to the Congress, "Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration." As in other States, the Illinois Department of Public Health was designated the responsibility for administering the MCH Block Grant. Like most of the states reviewed, Illinois would agree with the consensus that the block grant approach is more flexible and desirable than the alternative of categorical funding. We also have generally supported activities that were similar to those funded under the prior categorical program approach. Unlike some of the other states, Illinois has not decreased support to the Sudden Infant Death Syndrome program or to lead-based paint poisoning prevention activities. In fact, we are now moving to expand the lead-based paint poisoning program to a statewide program of technical assistance instead of continuing the limited direct service activity in one part of our State, which began as a result of categorical funding.

In terms of management, Illinois' experience also is quite similar to other States. We developed Rules and Regulations to ensure a consistent approach to administering MCH programs by our grantees, developed a uniform process for applying for funds, developed a uniform list of assurances for each grantee, implemented a uniform monitoring and evaluation system for grantees, utilized a MCH Block Grant Task Force to provide a monitoring and oversight function and worked closely with Governor Jim Thompson's Block Grant Management Task Force.

With the advent of the MCH Block Grant, however, Illinois did make some changes in priorities. Some of the grants under the old "Program of Projects" were discontinued in favor of higher priority programs administered at the local level. Other funding allocations stayed proportionally the same. For example, it was determined that in our State, Crippled Children's Services had been receiving 32.1 percent of all available Title V dollars. This percentage of allocation has carried over under the Block Grant.

Overall expenditures for MCH activities in Illinois are continuing to increase. During state FY'84 for example, more than 17 million state general revenue dollars are supporting MCH activities...up almost $750 thousand from SFY'83. In addition, expenditures from other sources such as co-payments from Medicaid reimbursements also increased.

One additional similarity to other states can be found in Illinois' approach to utilizing the MCH Block Grant. As with other states, we have integrated MCH Block Grant planning into overall state health planning and budgeting processes. The Illinois Legislature has developed a block grant oversight committee to review the use of all block grant funds received by the State. In addition, the Department of Public Health is required to prepare on a yearly basis a Human Services Plan. We use this mechanism as a means to describe how we intend to utilize the MCH Block Grant funds for the upcoming state fiscal year.

Rather than describe any further the similarities Illinois shares with other states in terms of administering the MCH Block Grant, I would prefer to discuss three major areas of interest to our State: first, future changes to the MCH Block Grant; second, how Illinois has used the inherent flexibility of block grants to develop innovative approaches to MCH programming; and third, funding levels for the block in FFY'85.

Changes to the MCH Block Grant

In terms of changes to the MCH Block Grant, Illinois has one major concern...that being the national allocation formula for the distribution of the MCH Block Grant funds to the states. In September, 1982, the Secretary of the Department of Health and Human Services reported to the Congress on "The Study of Equitable Formulas for the Allocation of Block Grant Funds" for three of the blocks including the Maternal and Child Health Services Block. At that time the Secretary recommended that no change be made in the existing allocation formulas, "since the Administration will be proposing legislation for the President's New Federalism initiative." Since the new federalism initiative of Mega-Blocks was unsuccessful, we would like to urge the Senate to request HHS to reopen the issue of the MCH formula with a view to developing a more equitable approach to allocating these block grant funds to the states. We firmly believe that states with larger numbers of mothers and children with serious health problems should be allocated larger shares of federal monies. At this time, Illinois with just under 5% of the nation's total population, receives only 4.3% 4.2% of the available MCH block grant funds. If the formula were allocated only on a per capita basis, and Illinois received its equitable share, the total amount allocated to the state would be increased by more than $2.2 million dollars. In addition, Illinois has the misfortune of having one of the nation's highest infant mortality rates. While the national provisional infant mortality rate for 1982 is 11.2/1000 live births, Illinois' rate for the same time period is 13.6. While this is down slightly from the 13.9/1000 live births experienced in 1981, it is still totally unacceptable. In addition to having a much higher than acceptable state rate, Illinois' largest city - Chicago - has one of the highest infant mortality rates among urban areas in the nation with an overall rate of 18.6/1000 live births, and a rate among non-whites of 24.8/1000.

Perhaps this year would be a good year to reopen the issue of the MCH Block Grant formula since it appears that the federal appropriation could well exceed this year's level of $373 million which could serve to minimize cuts in overall funding levels to states which might lose funding if a new formula were implemented. Such factors as low birthweight, high infant mortality rates, number of children under five living in poverty, and unemployment rates could all be useful indicators to develop a formula based more clearly on need. Perhaps a formula that allows for a shift of funding over a two to three year period would assist in solving the present maldistribution problem.

Innovations to MCH Programming through the MCH Block Grant

The State of Illinois has developed three major initiatives through the flexibility available as a result of the MCH Block Grant. The first major initiative occurred in FFY'82 - the first year of the block grants. At that time, Illinois dedicated a portion of the block grant for distribution to each region in the state in order to allow local health agencies an opportunity to develop and/or expand MCH activities at the local level, as well as to allow them to share in the whole concept of block grants. Through the RFP process, we invited local agencies to tell us what their local priorities for MCH programming were and to apply for a portion of the funds. As a result, 87 local agencies are providing MCH services; prior to block grants only a handful of these agencies participated in federally funded MCH projects. Of the 87 local agencies participating, most used their MCH Block Grant funds to begin or expand programs to provide medical, social and educational programs for adolescent and low income women designed to improve pregnancy outcomes. These services relate to follow-up of high risk infants and mothers, well child services, adolescent pregnancy programs, prenatal care and family planning services, parenting education, and other comprehensive maternal and child health services.

The second example of innovation through the flexibility of block grants took place this fiscal year as a result of the transferability of funds from one block grant to another...in this instance from the Social Services Block Grant to the Maternal and Child Health Block. Until this fiscal year, the state Medicaid program has used Medicaid dollars to reimburse physicians for immunizing agents used in childhood immunizations. By transferring Social Services Block Grant funds into the MCH Block, the State will save anywhere from $500 thousand to $1 million per annum by allowing the State Health Department to purchase childhood immunizing agents directly through our federal contracts at a much lower cost than what private physicians or clinics pay for the same vaccines. Through this mechanism, the State Health Department purchases vaccines and supplies them to private physicians instead of allowing the Medicaid program to reimburse physicians for the purchase of vaccines at a much higher cost.

The Parents Too Soon Program - the third example of innovations to MCH Programming through the MCH Block Grant - is by far the one in which the State of Illinois is most pleased. The Parents Too Soon Program (PTS) was announced in April, 1983, by Governor James Thompson as a major state effort to address the problems of teen pregnancy. Ten state agencies are participating in this multi-agency primary prevention program designed to reduce the number of unintended pregnancies and the many problems associated with child bearing at a very young age. The Parents Too Soon Program has been designed to provide a comprehensive range of coordinated services to prevent unintended/premature pregnancy, to prevent the health risks associated with teen parenting and to provide a variety of support services to adolescents and adolescent families.

The Parents Too Soon initiative came about through the infusion of funds to the MCH Block Grant, the Social Services Block Grant and the Women, Infants and Children Nutrition Program (WIC), through the 1983 Supplemental Jobs Bill. The State earmarked the entire amount of $4.168 million added onto the MCH Block Grant through Jobs Bill funds to the Parents Too Soon initiative. In addition $6.747 million of the Social Services Block Grant Jobs Bill add-on and $2 million from the $4.5 million supplement to the WIC program - for a total of $12,915 million of the State's total Jobs Bill Supplemental Funding - is being devoted to the Parents Too Soon Program.

The decision was made to launch the Parents Too Soon Initiative based on critical data relating to the adolescent pregnancy problem in Illinois. In 1982, there were 44,900 teen pregnancies. Of that number, 29% (12,936) had abortions and 14% (6,407) miscarried. 36% (16,217) were unmarried and ~~An~~ additional 21% (9,340) who gave birth were married. ~~in Illinois~~, just under 14% were to teens. In addition, the number of births to girls from 10 to 14 years of age rose 17% within a one-year period. At this time in Illinois, there are 150,000 infants and children under five living with 130,000 teen parents - two-thirds of these teens are under 17 years of age. 20,000 of the infants and children are siblings. Of all the teen pregnancies in Illinois, 80% are unintended. Of all teen pregnancies, 20% occur in the first month of sexual activity, and 50% occur in the first six months. We also know that the infant mortality risk is 46% higher for teens than for women, age 20-24. In addition, teens 15 and younger are twice as likely to have low birth weight babies. All of this disheartening data led Governor Thompson to make the decision to try to make an impact on the adolescent pregnancy problem by developing the Parents Too Soon Program. Much of the planning and the blueprint for action for this initiative was accomplished two years prior to the Supplemental Jobs Bill funding. The receipt of the additional funding made it possible for Illinois to move forward with implementation of our plan.

Since reduction of infant mortality has been the Department of Public Health's top priority since 1979, our Department was given the overall responsibility for coordinating the efforts of ten state agencies to develop a comprehensive approach to dealing with problems of adolescent pregnancy. The program is designed to ensure that teenagers who do become pregnant receive the medical attention necessary for a healthy delivery and a healthy infant: to make available to teens information on reproduction, family planning and parenting; and to provide a full range of social, educational and vocational services to enable teens to overcome the severe limitations of teen parenthood.

Ten state agencies are coordinating and targeting their services toward both girls and boys, ages 10 through 20, who are at risk of becoming parents, who are expecting a child or who are parents already. The ten agencies are: The Departments of Public Health, Public Aid, Children and Family Services, Mental Health and Developmental Disabilities, and Alcohol and Substance Abuse; the State Board of Education, Division of Services for Crippled Children, Bureau of Employment Security, Governor's Planning Council on Developmental Disabilities, and the Illinois Information Service. Detailed information on these agencies and their involvement in the PTS program as well as other aspects of the program, are included with Exhibit 1 attached to this testimony.

The Parents Too Soon program has four major goals:

-- To reduce the incidence of unintended pregnancy.

-- To reduce the incidence of infant mortality and to improve the emotional and physical health of infants and children of teens.

-- To mitigate the health risks faced by teens who bear children and to improve the parenting abilities of teens.

-- To keep pregnant teenagers and teen parents in school and to improve their job skills and job opportunities.

The Parents Too Soon program provides a number of major services including family planning, medical care for pregnant teens, adolescent mothers and their infants and young children; parenting training; food and nutritional counseling through the Special Supplemental Food Program for Women, Infants and Children; day care for infants and young children of teens who otherwise would be unable to remain in school or receive job training; vocational counseling and training; help with drug or alcohol-dependency problems and counseling.

The program provides services throughout the state. Special emphasis is placed upon areas where teenage pregnancy, infant mortality and unemployment are widespread. Due to budget constraints, all services are not available in all parts of the State. PTS not only provides state services directly, but also funds programs provided by public and private agencies established within communities. A toll-free, 24-hour hotline - 1-800-4-CALL US refers teens to appropriate agencies. A multi-media public awareness campaign was launched on May 20 to make the program better known throughout the State and to alert the general public of the problems of teen pregnancy.

Because the problem of teen pregnancy is complex, the state's approach to dealing with the problem is multifaceted. Two major factors worked together to allow Illinois to cross departmental lines and bring together the services of 10 state agencies. Those two factors were the flexibility of block grants and the Supplemental Jobs Bill Funding. In the past, a pregnant or parenting adolescent generally received only one type of service, such as health care or child care, but not both. This teenage population frequently needs special attention within a broader program; for example, an alcohol abuse program must recognize the unique dangers faced by pregnant teens.

Unlike the typical governmental program, in which a particular service is provided or funded by one specific agency, Parents Too Soon coordinates a full range of services provided by 10 state agencies and is funded primarily through block grants administered by the Departments of Public Health and Public Aid. Through interagency cooperation and by targeting its services, Parents Too Soon hopes to serve better and to reach a greater number of teenagers. While Parents Too Soon is a direct service program, it also provides a focus which alerts state agencies to the special needs of teenagers. It is a vehicle for reaching out across the state, in partnership with local agencies--both public and private.

Some 75 local agencies - including the State's 10 perinatal networks - throughout the State have been funded either through the MCH Block Grant or the Social Services Block Grant, to provide services as part of the PTS programs. These agencies, in the first nine months of operation, are now serving in excess of 13,000 teen clients.

Our emphasis is on networking and coordination. When we get a teen mother in the WIC program - and we have made special efforts to increase our ~~pre-parent~~ pregnant teen caseload - we try to ascertain whether or not that teen mother is receiving prenatal care, social services, and other related services. Illinois has been able to increase its eligible teen caseload in the Chicago area by applying for and receiving funds through the Commodity Supplemental Food Program (CSFP). By shifting caseload from WIC to CSFP, we have been able to serve additional teen mothers and their children in one of the areas of greatest need in the State. When a teen mother comes to a well-child clinic, we try to determine if she is in a teen support group - if she is still on WIC - if she is in a family planning program - if she has an interest in continuing her education. Local agencies are required to network with other community agencies to get that teen served. Once a teen is in the program, every effort is made to keep that teen in the program. Special efforts are being made with adolescent males - particularly through vocational/educational counseling and teen rap groups.

As part of the overall effort, the program has funded three demonstration projects - one, Mile Square Health Center, is in one of the City of Chicago's statistically most needy in terms of teenage pregnancy. The other two projects serve a quite different geographical mix; the Winnebago County health Department project works with teens from both urban and rural areas; while the Southern Seven Health Department serves the seven southernmost counties in the State where the population is primarily rural and health services in general are sparse. These three areas were selected because of their high rates of teenage births, infant mortality and unemployment. We are also in the process of working with the East St. Louis community to develop a fourth demonstration project in that depressed area.

In addition to providing comprehensive services to teens, the demonstration projects will provide a model for coordination of public and private efforts. Further, the demonstration projects will provide evidence to show whether such coordination, availability of service and intensive targeting to teens makes a discernible difference in the incidence of teenage pregnancy and its consequences. An evaluation design has been developed as the result of a grant from the Robert Wood Johnson Foundation. If the Foundation likes the designs we are hopeful that full funding will be made available for a three and one-half year evaluation of the entire project.

If additional funding were available, the Parents Too Soon Program would develop additional demonstration sites as well as augment grants going to local agencies to purchase perinatal, prenatal, family planning, teen parenting, and day care services.

FFY'85 Funding Level for the MCH Block Grant

The last major area I would like to address today is of concern to Illinois and other states as well as such professional groups as the American Public Health Association. That issue is the FFY'85 funding level for the MCH Block Grant. The funding level that Congress finally decides upon for the Maternal and Child Health Block Grant is critical to Illinois. As described in this testimony, we currently have several initiatives underway which, if they are to be continued at SFY'84 levels, will require additional support through the MCH Block Grant. The Parents Too Soon program, in particular, will suffer if the MCH Block Grant program is funded at the FFY'84 level. We urge you to seriously consider full funding at a level at least equal to that allocated in FFY'83 plus the Supplemental Jobs Bill level. We also, once again, urge you to request the Secretary of HHS to reopen discussion and review of the formula currently used to distribute MCH Block Grant Funds to the State.

Summary Statement

Thank you once again for this opportunity to testify on behalf of Illinois' experience with the MCH Block Grant. We in Illinois appreciate your attention and your favorable actions on our funding and formula recommendations.

Senator **Durenberger**. On the subject of title XX, "Social Services," let me ask you a question, and maybe the other two can react to this: Where were the lobbyists for your seniors when they were taking money out of title XX for kids and mothers?

Ms. **Randolph**. I can't really respond to that. Let me say that we would not have received as many title XX funds for the parents too soon program or for immunizations, had it not been for the supplemental jobs bill and had it not been for the fact that Governor Thompson was successful in getting a surtax onto the personal income tax in the State to help pay for general assistance.

The question might have been better phrased: Where were those receiving general assistance at that point in time? That would have included many more people in addition to the senior citizens.

So we were successful in those two areas—the supplemental jobs bill is what really gave Governor Thompson the funds to direct into the adolescent pregnancy program—plus the fact that we did have the flexibility inherent in the blocks that we could bring to bear against the problem . . . funds from the two major block grants that are dealing with this initiative, plus the WIC money.

If Senator Dole had been here I was going to be certain to tell him that we use WIC funds for the parents too soon program and we try to coordinate all of these services.

The key to our program is networking. Once we get a kid in, we want to keep that kid in, no matter where they come in.

Senator **Durenberger**. Now, there is some flexibility with block grants. If you were here when Senator Bumpers was here, we had a little interchange in which I described the way we respond to fiscal disparities in this country and to need. We raise the lake level rather than trying to take care of the most desperate; we just raise the lake level for everybody.

One of the things that we did in the energy crisis in 1979, of course, was to decided that it was bad policy to try to regulate prices of energy in this country. So we had to take a one-time big whammy in natural gas and electricity and other price increases, and we created the Fuel Assistance Program. As a typical Federal program, we were out on the floor debating that one longer, I think, than we have been debating the defense authorization bill, because if we were going to reflect the costs of keeping people from freezing to death in Minnesota, we were also going to have to reflect the cost of not having people die of exposure to excessive heat in Texas or Arizona.

Then, of course, it isn't just the 50 States. We sent heating money, in effect, to American Samoa and places like that that didn't really need it. So we now have something close to a $1.8 billion-a-year add-on for a problem that really should have started to solve itself after 1979.

But the money has been available, and some money has moved back and forth from that program into other block grant programs. I just wonder what your observation has been in terms of has there been some flexibility of moving funds in and out of programs and what has actually happened over the last several years.

Mr. **Gossert**. A couple of things in Colorado. We don't have a title XX problem because social services gets out all of the money and transfers none of it. Legislature, however, did appropriate about $140,000 of alcohol and drug abuse money to the maternal and child health side, and the alcoholism lobby in the legislature has been trying to reverse that for 3 years.

Senator **Durenberger**. Do you mean the treatment lobby?

Mr. **Gossert**. Yes. It was drug and alcohol block money. You can transfer 7 percent of that; $140,000 of it was transferred to the maternal and child health arena.

The other thing that has happened, just coincidentally, is that in the preventive block, which is probably the most flexible blocks, Colorado's legislature has learned how to appropriate that by cutting general funds in areas where a preventive block can be used; therefore, ipso facto, appropriating preventive block money.

Senator **Durenberger**. Any observations from Arkansas?

Mr. **McGrew**. I would like to make a comment on title XX. I think there is something there that is terribly important that we are going to have to deal with in the future with MCH. In our State, 14 percent of the population is 65 or over, second only to Florida in the percentage over 65. And as we continue to age as a Nation, one of the things that happens is that, you know, we've got more people who are going to be a little bit less concerned about kids, about health care, about education, and we are beginning to see that in Arkansas. The title XX, as far as money that went for aging, I can assure you that the aging folks were organized and did show up at the public hearings. They wanted to make sure that none of that money was transferred to other services, because there is inadequate funding for services for the elderly in that State, especially with our very large population.

We have, on the other hand, with the preventive health block, used part of that funding for MCH immunization—again, in the overall scheme of things and what our priorities were for the agency. It is not that things that were being funded there previously were not a priority; it's just that with MCH it is so clear that we cannot only tremendously improve the quality of life for mothers and infants but we can also save a lot of money for both the State and Federal Governments down the road.

So, unfortunately, it is just a matter of several priorities and not enough money to fund them. You take from one to fund the one that you feel you will get the very most from, and that happens to be MCH.

Senator DURENBERGER. Part of the statement on behalf of the National Association of Counties, NACO, was that too much money from the block grant is going to support administrative activities at the State level. How would you all react to that?

Ms. RANDOLPH. We don't use any of it for administration. State general revenue funds pays for all of the administration. The entire amount of our block grant goes out as a grant to someone else or to pay, in one program, perinatal costs for about 6 percent of our high risk population who are not eligible for public aid, do not have private insurance, and would really be truly medically indigent. So all of our money goes out, and the State general revenue fund picks up all of the costs for our staff.

Mr. MCGREW. As far as we are concerned, very little money goes for administration. Again, as I mentioned earlier, we have a different organizational structure, and the people in the counties are part of our organization and have a very strong voice in how money is spent. So, if we were keeping a lot of it in the central office for things that were not appropriate, we wouldn't have to wait for people outside the organization to be telling us that that was not the right priority.

Mr. GOSSERT. In Colorado it is a little bit different. Our handicapped children's program is a directly operated program, so we have service people. Some of those are based across the State.

Our administrative costs are hard to compute, because when you have a nurse who is in charge of a maternity program and does quality assurance and technical assistance, is that administration, or is that something else?

I can say, however, that we have less staff at the State level than we had in 1982 and 1981.

Senator DURENBERGER. All right.

Thank you all very much for your testimony. I appreciate it a great deal.

I believe that ends our hearing, and we will stand adjourned.

[Whereupon at 12:42 p.m., the hearing was concluded.]

[By direction of the chairman the following communcations were made a part of the hearing record:]

AMERICAN FOUNDATION FOR THE BLIND, INC.

GOVERNMENTAL RELATIONS DEPARTMENT

1660 L STREET, N.W.
SUITE 214
WASHINGTON, D.C. 20036
TEL: 202 467-5996

UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

HEARING ON

MATERNAL AND CHILD HEALTH BLOCK GRANT

JUNE 20, 1984

STATEMENT OF

BARBARA D. MCGARRY
SPECIALIST IN GOVERNMENTAL RELATIONS

FOR THE

AMERICAN FOUNDATION FOR THE BLIND

THE AMERICAN FOUNDATION FOR THE BLIND APPRECIATES THIS OPPORTUNITY TO EXPRESS OUR VIEWS ON THE STATUS OF THE MATERNAL AND CHILD HEALTH BLOCK GRANT, AND IN PARTICULAR ONE OF ITS COMPONENTS, THE SSI BLIND AND DISABLED CHILDREN'S PROGRAM, AS REVIEWED IN THE MAY 7, 1984, REPORT OF THE GENERAL ACCOUNTING OFFICE.

15 WEST 16TH STREET NEW YORK N.Y. 10011 / TEL (212) 620-2000
CABLE ADDRESS FOUNDATION NEW YORK/AN EQUAL OPPORTUNITY EMPLOYER

FIELD OFFICES
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Region IV 100 Peachtree Street, Atlanta, Georgia 30303 (404) 525-2303
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Region VI 760 Market Street, San Francisco, California 94102 (415) 392-4845
Legislative Office — 1660 L Street, N.W., Washington, D.C. 20036 (202) 467-5996

SINCE ITS ESTABLISHMENT IN 1921, THE AMERICAN FOUNDATION FOR THE BLIND HAS SUSTAINED PARTICULAR CONCERN FOR CHILDREN BORN WITH THE DOUBLE HANDICAP OF A PHYSICALLY DISABLING CONDITION, AND SEVERELY IMPOVERISHED FAMILY CIRCUMSTANCES. WE THEREFORE STRONGLY SUPPORTED ENACTMENT AND EXTENSION OF THE ORIGINAL DISABLED CHILDREN'S PROGRAM, FOR BLIND OR OTHERWISE DISABLED CHILDREN UNDER THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM. AS THE ATTACHED TABLE CONFIRMS, THERE ARE ALMOST A QUARTER OF A MILLION OF THESE CHILDREN, FOR WHOM THIS PROGRAM HAS REPRESENTED AN ASSURANCE OF MEDICAL, HABILITATIVE, AND SOCIAL SERVICES THAT MIGHT NOT OTHERWISE BE PROVIDED.

WHEN THE DISABLED CHILDREN'S PROGRAM WAS SUBSUMED IN 1981 UNDER THE MATERNAL AND CHILD HEALTH BLOCK GRANT, OUR ORGANIZATION EXPRESSED CONCERN OVER WHETHER THE SPECIFIC NEEDS OF THESE CHILDREN WOULD CONTINUE TO BE MET. OUR ATTEMPTS TO ASCERTAIN WHETHER SUCH SERVICES WERE BEING CONTINUED WERE, OF COURSE, MADE MORE DIFFICULT BY THE LACK OF REPORTING REQUIREMENTS UNDER THE NEW BLOCK GRANT. CONSEQUENTLY, WE ARE ESPECIALLY INTERESTED IN THE CONGRESSIONALLY MANDATED REPORT BY GAO, ISSUED IN MAY, 1984, ON THE CURRENT STATUS OF THE MCH BLOCK GRANT WHICH, WE HOPED, WOULD ALSO PROVIDE FULL UPDATED INFORMATION ON THE SURVIVAL OF THE SSI DISABLED CHILDREN'S PROGRAM.

UNFORTUNATELY, THE GAO REPORT DOES NOT PROVIDE SUFFICIENT DOCUMENTATION. IT IS LIMITED TO A THIRTEEN-STATE SURVEY—CALIFORNIA, COLORADO, FLORIDA, IOWA, KENTUCKY, MASSACHUSETTS, MICHIGAN, MISSISSIPPI, NEW YORK, PENNSYLVANIA, TEXAS, VERMONT, AND WASHINGTON.

IN ADDITION, A BASIC FLAW IN THE REPORT—AT LEAST IN TERMS OF POPULATIONS SERVED — IS THE FAILURE TO LIST ANWHERE IN THE REPORT THE DECREASE OR INCREASE IN NUMBERS OF CHILDREN SERVED IN EACH STATE

SURVEYED. INSTEAD, THE REPORT MERELY NOTES EXPENDITURE CHANGES FOR SSI CHILDREN SINCE 1981, WITH ANY INCREASES UNDOUBTEDLY DUE AT LEAST IN PART TO THE 15% ANNUAL INCREASE IN MEDICAL COSTS. THE REPORT DOES EMPHASIZE, HOWEVER, THAT THE 13 STATES SURVEYED DO REPRESENT APPROXIMATELY 45 PERCENT OF TOTAL FUNDS AVAILABLE IN THE MCH BLOCK GRANT.

THE INITIAL IMPACT OF THE 1981 FUNDING REDUCTION, ACCORDING TO GAO, CAUSED MANY OF THESE 13 STATES TO BORROW FROM OTHER BLOCK GRANTS——MENTAL HEALTH, TITLE XX, ENERGY, PREVENTIVE HEALTH SERVICES, AS WELL AS THE EPSDT PORTION OF MEDICAID. ALSO, THE "JOBS BILL" ENACTED IN MARCH 1983 PROVIDED AN ADDITIONAL $105 MILLION FOR MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES, WHICH GAO INDICATES WAS USED MAINLY FOR "ECONOMICALLY DISADVANTAGED" FAMILIES DURING A PERIOD OF HIGH UNEMPLOYMENT. (P. 19, REPORT).

HOWEVER, "THE PREDOMINANT CRITERIA [THAT] STATES CONSIDERED IMPORTANT IN DETERMINING WHO IS ELIGIBLE FOR CRIPPLED CHILDREN'S SERVICES WERE NEED FOR SERVICES AND AGE. MANY STATES ALSO CONSIDERED FAMILY INCOME TO BE IMPORTANT." (P. 31, REPORT).

ELSEWHERE IN THE REPORT, CONCLUSIONS WERE SIMILARLY IMPRECISE IN EVALUATING SSI CHILDREN'S TREATMENT UNDER THE MCH BLOCK GRANT. ON PAGE 20, REVIEWING THE TWO-YEAR PERIOD OF 1981-1983, WE LEARN THAT "EXPENDITURES FOR SERVICES TO SSI DISABLED CHILDREN DECREASED IN SEVEREAL STATES, AS THEIR SERVICES AND RELATED EXPENDITURES WERE ACCOUNTED FOR IN CONJUNCTION WITH THE CRIPPLED CHILDREN'S SERVICES PROGRAM AREA." IN FOUR OF THE SEVEN STATES THAT CONSOLIDATED [SSI DISABLED CHILDREN INTO CRIPPLED CHILDREN'S SERVICES], GAO STATES THAT "EXPENDITURES FOR CRIPPLED CHILDREN'S SERVICES INCREASED" (P. 21), THEN DEEPENS THE AMBIGUITY BY ADDING THAT

> "ALTHOUGH THESE STATES COULD NOT ALWAYS READILY IDENTIFY HOW MUCH OF THEIR 1983 EXPENDITURES RELATED TO THE FORMER SSI PROGRAM, THIS CONSOLIDATION WOULD ACCOUNT FOR ONLY A SMALL PORTION OF THE CRIPPLED CHILDREN'S SERVICES INCREASES, BECAUSE THE 1981 SSI EXPENDITURES IN THESE 7 STATES TOTALLED ONLY ABOUT $1.9 MILLION." (P. 21, REPORT).

WE FIND THIS STATEMENT PARTICULARLY UNSETTLING IN VIEW OF THE FACT THAT 4 OF THE 13 STATES IN THE GAO STUDY STILL MAINTAIN A SEPARATE PROGRAM FOR SSI CHILDREN. THE NUMBER OF BLIND AND DISABLED SSI CHILDREN IN EACH STATE IS PUBLIC KNOWLEDGE, AND WAS MOST RECENTLY PUBLISHED IN THE ANNUAL STATISTICAL SUPPLEMENT FOR 1982 OF THE SOCIAL SECURITY BULLETIN, A COPY OF WHICH IS ENCLOSED.

IN SUMMARY, THE GAO REPORT FURTHER STRENGTHENS OUR CONVICTION THAT THE SELF-EVIDENT NEEDS OF A DISCRETE SEGMENT OF OUR POPULATION CANNOT BE WELL SERVED THROUGH THE BLOCK-GRANT MECHANISM. UNTIL SUCH TIME AS CONGRESS ENACTS LEGISLATION MORE PRECISELY RESPONDING TO THESE NEEDS —— AND IN REPORTING H.R. 5538, CONGRESS HAS SERVED NOTICE OF SECOND THOUGHTS ABOUT PRESERVING THE PRESENT STATUS OF THE MCH BLOCK GRANT——AT THE VERY LEAST, THERE MUST BE A MANDATED PRIORITY TO ASSURE SERVICES TO THE 7,198 BLIND AND 221,953 MULTIPLY DISABLED CHILDREN IN THE SSI PROGRAM, AS AN INTEGRAL PART OF THE MATERNAL AND CHILD HEALTH BLOCK GRANT APPROPRIATIONS PROCESS.

Table 180.—Total amount, Federal SSI payments, and State supplementation, by State, 1982

[In thousands]

State	Total	Federal SSI	State supplementation	
			Federally administered	State administered
Total	$8,981,328	$6,907,043	[1] $1,798,453	$275,832
Alabama	237,836	226,506		11,330
Alaska	9,079	6,511		[2] 2,568
Arizona	64,579	63,182		1,397
Arkansas	119,934	119,885	49	
California	2,100,243	894,358	1,205,885	
Colorado	92,506	53,803		38,703
Connecticut	71,294	47,999		23,295
Delaware	13,109	12,664	445	
District of Columbia	35,987	32,094	3,893	
Florida	362,357	358,949	(3)(4)	[4] 3,408
Georgia	270,283	270,255	28	
Hawaii	23,702	19,334	4,368	
Idaho	16,894	13,564		3,330
Illinois	274,239	246,084		28,155
Indiana	73,456	72,952		[2] 504
Iowa	40,710	39,646	[4] 1,064	(4)(5)
Kansas	32,968	32,918	50	
Kentucky	190,458	179,712		10,746
Louisiana	246,297	246,202	[4] 95	(4)(5)
Maine	33,222	28,562	4,660	
Maryland	98,606	97,527	[4] 142	[4] 937
Massachusetts	254,384	139,956	114,428	
Michigan	259,425	201,675	57,750	
Minnesota	60,067	47,892		[2] 12,175
Mississippi	200,621	200,555	66	
Missouri	183,402	146,352		37,050
Montana	12,656	11,903	753	
Nebraska	28,215	22,653		5,562
Nevada	14,471	11,831	2,640	
New Hampshire	15,926	9,657		6,269
New Jersey	197,667	160,516	37,151	
New Mexico	48,630	48,383		247
New York	879,934	659,850	220,084	
North Carolina	273,180	245,457		27,723
North Dakota	11,239	9,751		1,488
Ohio	235,616	235,544	[4] 72	(4)(5)
Oklahoma	147,717	108,062		39,655
Oregon	51,289	42,730		8,559
Pennsylvania	346,806	291,180	55,626	
Rhode Island	29,341	22,156	7,185	
South Carolina	148,979	146,561		2,418
South Dakota	12,967	12,459	[4] 33	[4] 475
Tennessee	232,580	232,580	(3)	
Texas	421,341	421,341	(6)	(6)
Utah	14,878	14,169		709
Vermont	18,065	12,819	5,246	
Virginia	154,091	145,133		8,958
Washington	95,277	79,266	16,011	
West Virginia	84,848	84,848	(6)	(6)
Wisconsin	135,479	74,514	60,965	
Wyoming	3,119	2,950		[2] 169
Other areas:				
Northern Mariana Islands	[1] 1,590	1,590	(6)	(6)

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[1] Payments reduced by $233,000 to reflect returned checks and overpayment refunds. For fiscal year 1982, includes $19.8 million of Federal contributions to State supplementation under the "hold-harmless" provision. For "hold-harmless" provision, see page 267.

[2] Partly estimated.

[3] Data not shown; adjustment totals exceed the actual amounts paid during the year.

[4] Mandatory payments are federally administered and optional payments are State administered.

[5] Data not available.

[6] State payments not made.

Table 181.—Number of blind and disabled children receiving federally administered payments, 1974–82 and by State, December 1982

State	Total	Blind	Disabled
1974	70,900	3,100	67,800
1975	128,175	4,346	123,829
1976	153,128	4,886	148,242
1977	175,214	5,106	170,108
1978	197,499	5,764	191,735
1979	212,088	6,224	205,864
1980	228,564	6,853	221,711
1981	230,094	7,107	222,987
1982	229,151	7,198	221,953
Alabama	6,178	122	6,056
Alaska	198	8	190
**Arizona	2,178	67	2,111
Arkansas	3,634	132	3,502
California	23,063	940	22,123
*Colorado	2,061	79	1,982
Connecticut	1,713	91	1,622
Delaware	582	23	559
District of Columbia	698	11	687
*Florida	9,119	276	8,843
Georgia	7,747	195	7,552
Hawaii	479	25	454
*Idaho	772	18	754
**Illinois	7,951	240	7,711
**Indiana	3,376	181	3,195
*Iowa	2,176	138	2,038
*Kansas	1,550	37	1,513
**Kentucky	5,128	174	4,954
Louisiana	10,147	219	9,928
*Maine	1,016	38	978
Maryland	2,994	93	2,901
**Massachusetts	5,258	459	4,799
*Michigan	6,220	219	6,001
*Minnesota	2,055	98	1,957
*Mississippi	6,476	150	6,326
*Missouri	4,213	101	4,112
Montana DISCONTINUED	521	20	501
**Nebraska	1,087	22	1,065
Nevada	468	48	420
New Hampshire	470	16	454
New Jersey	6,364	132	6,232
New Mexico	1,435	51	1,384
**New York	24,061	393	23,668
*North Carolina	6,570	226	6,344
North Dakota	296	14	282
*Ohio	8,966	304	8,662
**Oklahoma	2,760	92	2,668
*Oregon	1,934	74	1,860
**Pennsylvania	11,953	323	11,630
**Rhode Island	1,022	38	984
South Carolina	4,761	161	4,600
South Dakota	673	22	651
Tennessee	6,779	205	6,574
**Texas	16,625	476	16,149
*Utah	862	32	830
*Vermont	513	12	501
Virginia	4,295	151	4,144
*Washington	3,012	75	2,937
West Virginia	2,348	56	2,292
Wisconsin	4,200	115	085
Wyoming	116	4	112
Other areas:			
Northern Mariana Islands	78	2	76

*This state has consolidated SSI with Crippled Children's Services.

**This state continues to provide a separate SSI Disabled Children's Program.

STATEMENT
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

Improving the health of the mothers and children of this nation has always been a top priority for the Association of State and Territorial Health Officials (ASTHO). There is no question that a healthy beginning in life will greatly benefit the future lives of all people.

ASTHO has strongly endorsed the block grant concept as the most effective means to deliver maternal and child health services in the states. The flexibility of block grants has enabled each individual state to assess needs, set priority areas, target funds to those areas of need, and innovate new and important programs.

Federal funding levels need to reflect the tremendous impact that MCH programs have on the lives and futures of our children. Increased funding is necessary to meet the continually expanding universe of mothers and children eligible for services. The states cannot independently continue to provide all the funding needed for the increased case load if federal support continues to erode. In many states, additional state funding that would have gone for an expansion of services were used instead to replace losses from the federal grant after the changeover to the MCH Block Grant. Therefore, ASTHO urges a significant increase in the MCH funding level - a doubling of the current $398 million 1984 appropriation.

In general, ASTHO has found the present MCH Block Grant legislation working well and of great benefit to the states' desire for flexibility. However, in order to maintain the principle of the block grant we would like to see less money diverted to Special Projects of Regional and National Significance (SPRANS). In April 1984 ASTHO adopted a resolution which caps SPRANS money at the FY '84 funding level (see attached). If there is any increase in appropriation to MCH, the entire increase should be alloted to states for use by them in block service activities.

An additional change to the administration of the MCH Block that would be helpful to states is extension of the time permitted to expend funds beyond obligation. Invoicing of expenditures from contractors often is later than allowed for by the block grant legislation.

In regards to the May 7, 1984 GAO Report on the MCH Block Grant, the states involved in the study were in general agreement that the report accurately reflected the situation in those states. However, because of the short experience with the block grants, any conclusions reached as a result of the report data would be premature as to the effect of the MCH Block Grant on Maternal and Child Health throughout the nation.

RESOLUTION

IN SUPPORT OF INCREASING THE PROPORTION OF MATERNAL AND CHILD BLOCK GRANT AVAILABLE FOR FORMULAE ALLOCATION TO THE STATES

WHEREAS the MCH Block Grant is presently split between 85% allocation to the states and a 15% set-aside for special projects of regional and national significance; and

WHEREAS the ASTHO has supported the principal of the Block Grant approach to federal support to the states of public health services; and

WHEREAS the President's Budget Request for FY 1985 recommends 100% allocation to the states; and

WHEREAS the ASTHO recognizes the continued need, at a constant level of support, of special projects of regional and national significance: Therefore be it

RESOLVED, that ASTHO supports the allocation of all future MCH Block Grant increases into the existing formula for state program services, with the set-aside for special projects capped at the FY 84 funding level

CHILDREN AND FEDERAL HEALTH CARE CUTS

A National Survey of the Impact of Federal Health Budget Reductions on State Maternal and Child Health Services During 1982

A WHITE PAPER

Prepared by the
Children's Defense Fund
Washington, D.C.

Sara Rosenbaum
Judith Weitz

Principal Researcher, Dr. Mary Tierney

OVERVIEW AND MAJOR FINDINGS

I

Many thousands of poor mothers and children face health emergencies. They are being denied services vital to life and health as a result of federal budget cutbacks, unemployment, and shrinking state coffers.

- Every state (100 percent) has reduced its Medicaid program for mothers and children by cutting back on services and/or making eligibility more difficult.
- Forty-seven states (94 percent) reported cutbacks in Title V Maternal and Child Health Block Grant programs during 1982 by reducing eligibility and/or health services.
- 725,000 people, 64 percent of whom are children and women of childbearing age, have lost services at Community Health Centers because of federal funding cuts affecting 239 centers--28 percent of all Community Health Centers in the nation.

II

Babies are needlessly dying and facing lifelong impairment for lack of adequate health care. Areas of the country suffering some of the sharpest decreases in the availability of public health services are also beginning to report a significant rise in infant mortality. This rise is correlated with increased poverty, deprivation, and an increased need for health care in an era of reduced public support for services.

- After an intensive effort in Alabama to decrease infant mortality, officials report that the state's infant death rate is now back at the 1980 level when Alabama had the highest infant mortality rate in the nation.

- In Ohio over 700,000 people are out of work. The state health department estimates that over one million Ohioans have no health insurance. Potentially, in the next three years alone, 60,000 children will be born to Ohio parents who have lost health insurance due to unemployment or underemployment. A preliminary look at seven Ohio counties reveals that as unemployment increases so does infant mortality. In the county that includes Youngstown, where unemployment is 18.6 percent, the infant mortality rate increased from 13.7 percent to 14.9 percent between 1980 and 1981.

- In some parts of Detroit, the infant death rate has hit 33 per 1,000 live births, the same death rate as Honduras, the poorest country in Central America. (Inadequate prenatal care contributes to infant mortality. One percent of all mothers who gave birth in 1979 in Detroit--386 women--did not see a doctor until the day of their delivery. Among these women, the infant mortality rate was 88 percent.) Warren, Michigan, has seen a 53 percent increase in its infant mortality rate; Pontiac, a 17 percent increase; and Flint, a 12 percent increase. Poor economic conditions, high unemployment, and unprecedented reductions in public health services contribute to these increases.

III

Almost 700,000 children have lost Medicaid coverage because of the cuts in the AFDC cash assistance program made by Congress at the Reagan Administration's request in 1981. Additionally, some states have made deeper Medicaid cuts than Congress required in the 1981 budget bill.

- Officials who have analyzed Medicaid eligibility trends in their state during 1982 uniformly report that the overriding cause of lost Medicaid eligibility was the restrictions placed on the AFDC program under the Omnibus Budget Reconciliation Act of 1981 (OBRA). Loss of AFDC also means loss of Medicaid. Since almost 70 percent of all AFDC recipients are children, they have borne the brunt of the Medicaid eligibility cuts emanating from federal welfare reductions.

- In addition to AFDC-caused reductions in Medicaid eligibility, 17 states (Alabama, California, Delaware, Florida, Georgia, Hawaii, Kansas, Michigan, Mississippi, Missouri, Montana, North Carolina, Oregon, Rhode Island, South Carolina, Virginia, and Washington) cut Medicaid more than required by federal AFDC cuts, to the detriment of children. Specifically, 13 states (Alabama, Delaware, Florida, Georgia, Hawaii, Kansas, Mississippi, Montana, North Carolina, Oregon, Rhode Island, South Carolina, and Virginia) have eliminated coverage for some or all categories of children between the ages of 18 and 21. Five states (California, Kansas, Michigan, Missouri, and Virginia) have tightened financial eligibility criteria. Four states (Montana, Utah, Missouri, and Washington) eliminated benefits for two-parent unemployed families.

IV

Many states report significant increases in Medicaid caseloads because of unemployment. Some of these same states have had to make the severest health care cuts, despite the number of "new poor families" in need of health services, because of economic conditions.

- During the second half of 1982, 21 states experienced increases in their Medicaid caseloads. In 16 of the states (Arkansas, California, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Nevada, New York, Ohio, Pennsylvania, South Dakota, Utah, West Virginia, and Wisconsin), officials reported that these increases were caused by unemployment.

- In Michigan, where unemployment is at depression levels, the state has been forced to make deep cuts in public Maternal and Child Health programs at the very time that the demand for public health services is surging. Eligibility criteria for Medicaid benefits have been reduced, making it more difficult for poor families to qualify for aid. The state also closed three public health clinics serving 6,000 pregnant women and 11,000 children, and two Family Planning Projects which had served 58,500 women. The state predicts 9,700 unanticipated pregnancies will result from the unavailability of Family Planning Services. Additionally, five Community Health Centers have been cut, affecting some 15,000 patients statewide.

- Utah, Montana, Washington, and Missouri eliminated their AFDC programs for two-parent unemployed families, which also would have provided these uninsured families with Medicaid benefits.

- Wyoming and Missouri officials reported that they were seeing two-parent families split up in order to qualify for the assistance available only to single-parent families.

V

Just when health care cost containment is critically needed, cost-effective prenatal and delivery services for pregnant women and primary and preventive services for infants and children are bearing the brunt of Title V Maternal and Child Health Block Grant cutbacks.

- Forty-four states (93 percent of those reporting reductions in their Title V programs) reduced prenatal and delivery services for pregnant women, and primary and preventive services for women of childbearing age, infants, and children. Twenty-seven states (57 percent) reduced their Crippled Children's Services.

- Thirty-seven states (82 percent of those reporting Title V reductions) reduced or eliminated services offered by the Title V programs of projects. Children and Youth Projects were the most frequently affected.

- Thirty-one states reduced or eliminated Medicaid services important for mothers and children, including new limitations on hospital, physician, clinic, and prescribed drug services.

THE HUMAN COST OF DENIED HEALTH SERVICES

Dwayne

Dwayne, an 11-month-old child from Youngstown, Ohio, nearly lost his life needlessly. Until his father lost his job at the steel mill, Dwayne had gotten regular medical care from a pediatrician in Youngstown. With the lost job, Dwayne's family lost their health insurance and they turned to the local health department, which provides health care to unemployed families at no cost. Even though the number of families using the health department clinic has doubled in the past year, mainly because of unemployment, budget cuts have forced the clinic to cut staff. As a result, Dwayne had to wait two months for an appointment.

In the meantime, Dwayne's family budget became so strained that his parents began giving him low-fat milk instead of higher-priced formula. By the time Dwayne was seen at the clinic he had become severely anemic and was "in a critical state." He was rushed to the hospital where he was given two transfusions and spent a week. When he was released the doctors placed him on the federally funded WIC supplemental food program, which provides him with the formula, juice, and cereal needed to prevent a recurrence of anemia.

The two-month waiting list at the local clinic continues. With unemployment in Mahoning County at nearly 19 percent, more and more parents are taking their young children off formula as a way to stretch their limited family budgets.

Dwayne's week in the hospital cost over $1,400. A thorough physical examination and an adequate supply of formula cost less than $100. The cost of any permanent damage to his health is yet to be determined.

Sheila

Sheila is a pregnant 17-year-old living in Kentucky with her unemployed 19-year-old husband and her mother, whose $650 a month paycheck supports the three of them. Until two months ago, Sheila was able to get prenatal care because she lived in Pennsylvania, which provided Medicaid coverage to indigent pregnant women whose husbands lived at home. Kentucky does not provide such assistance. The only way Sheila could get Medicaid would be if her husband abandoned her.

In past years, Sheila might have turned, as many poor uninsured women have, to the Lexington, Kentucky, Improved Pregnancy Outcome (IPO) Project for help. IPO Projects, run by state Title V agencies, assist indigent women like Sheila in getting adequate prenatal and delivery care. This year, however, funds were slashed for the IPO, forcing the project to curtail care for nearly half its current caseload. The chance that the IPO will take on a new patient like Sheila is almost nonexistent. Sheila has gone for two months without prenatal care. No one knows what will happen when she is ready to deliver her baby, since the family has no money to pay for a hospital bed.

Baby Doe

Children who are U.S. citizens born to undocumented Mexican aliens working in the San Joaquin Valley to gather the state's annual $13.9 billion agricultural harvest are being denied Medicaid cards. In at least one county, officials cut Medicaid benefits for dozens of these children. Welfare officials ruled that the children were not legal residents of the county because their mothers had said that, if deported, they would not relinquish custody of their children. A year-old infant was severely burned and undergoing skin grafts when the county decision led doctors to stop the grafts. Asked why aid was cut, the welfare director said, "It's a question of money. We can't cover everybody." Treatment was resumed only after the courts intervened.

Linda

Linda is employed at the Wendy's Hamburger chain in Mississippi on a part time basis. Her gross income from her job is about $85 a week. Her job carries no health insurance benefits. In December 1981 she was dropped from the cash assistance program because her income was too high. Consequently, she lost Medicaid coverage.

Linda has a four-year-old child who has been hospitalized for pneumonia. Luckily, the family had Medicaid coverage at that time. When the child got sick with a cold the following winter, Linda did not take her to the doctor because she did not have the money and was no longer covered by Medicaid. She came down with pneumonia again and was hospitalized. The bill came to $134. Linda was unable to pay. The medical center turned the bill over to a collection agency.

Since she lost cash assistance and Medicaid, Linda's rent has also been raised and the number of hours she works has been reduced. Other current financial obligations include a car note of $58 per month, loan payments of $50 per month for car repairs, a $70 per month utility bill, and $40 per month in transportation costs. When she was divorced, the child's father was asked to pay $75 per month in child support payments. To date, he has paid only a small portion of these payments. When Linda lost her cash assistance, she was also told that the

Department of Public Welfare would assist her in getting child support payments only if she paid a $20 fee. While the Department has not located the father, they have requested that Linda pay an additional $35 to have legal papers filed in court.

Ms. Y

A young woman in Alabama, pregnant for the first time, had been getting prenatal care from a private doctor and had made arrangements to have her baby delivered at the local hospital. Her care was covered by the health insurance her husband received as a benefit for his work as a steelworker. About half way through her pregnancy, he was laid off and lost his health insurance benefits. Though they were now indigent, because both parents lived at home she could not qualify for help under Alabama's Medicaid program. Her doctor told her not to come back since she had no way to pay the bills. She went six weeks without prenatal care. She didn't know where to go or whom to ask for help, since she'd never used the public health and welfare system before. Finally, in desperation, she approached a television station. The television station broadcast her story, but no one stepped forward to help her. Then her husband left home. Because she was now a single low-income prospective parent, Alabama's Medicaid program could cover her and she was able to get prenatal care again.

Being a Poor Woman in Labor in Missouri

Missouri, in order to save money, has been making it harder for families to apply for aid and for health providers to obtain the reimbursement they are owed. As a result, some hospitals in St. Louis, in order to discourage Medicaid admissions, have begun charging pregnant women in labor a $250 preadmission deposit for "nursery costs" for their unborn children. Women who cannot pay are being turned away. Many are flooding the public hospital, already stretched to capacity. As one advocate said: "We used to have poor women giving birth in the fields; now it's happening in their bedrooms."

WHAT MUST BE DONE NOW

Not another cut in federal health programs for mothers and children should be tolerated. The only result will be more suffering and death. A child's chances of living or dying, growing up healthy or impaired, should not depend on whether his parents are rich or poor, employed or unemployed, together or single, or live in Kentucky rather than Pennsylvania.

1. Immediate positive action to meet the health emergency is needed by providing Medicaid to every poor child and mother in "old" and "new" poor families alike. The sole eligibility criterion for Medicaid should be poverty.

2. Funding for the Title V Maternal and Child Health Block Grant must be increased.

3. Funding for the Community Health Centers Program must be increased. We must ensure that the basic network of public health providers--the lifeline to the uninsured and poor in America--is able to respond to the demand for health care by the growing numbers of poor and uninsured families in America.

HOW TO PAY FOR THESE IMMEDIATELY NEEDED ACTIONS

We can pay for these recommendations simply by having the Reagan Administration, Congress, and state officials make decent and fair choices about what they decide to cut and what they decide to pay for in their budget decisions. We think most Americans would agree that healthy mothers and children are more important than nonessential or questionable defense expenditures and tax cuts for the nonneedy.

- The Department of Defense owns a hotel at Fort Dean Russey on Waikiki Beach. The military resort was completed after the end of the Vietnam War. It is currently a popular vacation spot for military officials and retirees. Its fair market value is $100 million. The sale of the hotel would finance Medicaid coverage for all poor pregnant women.

- The Reagan Administration proposes to build 240 MX missiles (but base only 100). Each missile will cost American taxpayers $110 million. If we build 239 missiles--one less--we can finance the cost of Medicaid for every pregnant woman living below the poverty level.

- If we delay the beginning date of the third year of the individual tax cut scheduled to begin July 1, 1983, to July 12 (12 days), we can generate enough money to finance Medicaid coverage for all children living below the federal poverty level. Each day of delay equals $100 million in federal revenues. If we delay the individual tax cut until July 15, 1983,(15 days), we can finance all three recommendations.

- We will be building 100 B-1 bombers at a cost of $250 million each. If we build 91 B-1 bombers--nine fewer--we can finance Medicaid for all pregnant women and children living below federal poverty levels. Surely, this will not threaten our national security.

- Military bands cost $100 million. By using volunteer high school bands to play at patriotic events, we will be able to provide an additional $100 million for the Community Health Centers Program and perhaps interest more young people in patriotic activities.

- The TR-1 spy plane costs $40 million. We will be building 35 of them. If we build 32--or three less--we could add $120 million to the Title V Maternal and and Child Health Block Grant Program.

- If we scrap one nuclear-powered aircraft carrier ($3 billion), we can accomplish all three objectives and have over $1.5 billion left over to help provide jobs for unemployed poor parents.

STATE-BY-STATE CUTBACKS

Individual charts giving detailed descriptions of program reductions made by each state follow.

The federal budget cuts have affected each state differently States such as Alabama, Michigan, Arkansas, Missouri, Kentucky, and Washington have been severely affected by the unemployment and recession caused or exacerbated by Reaganomics. They have been unable to generate adequate state revenues to offset the damage resulting from federal cuts. Alaska, with its strong revenue base, has been able to expand modestly its public maternal and child health services. North Carolina, Tennessee, Maryland, and Iowa, despite the difficulties caused by the recession, have attempted to offset some of the cuts they made by modestly improving their Medicaid programs for poor pregnant women and children. Finally, there have been some innovative approaches, most notably New York State's legislation creating a special pool of insurance funds (including Medicare funds under special waiver authority granted by the United States Department of Health and Human Services) to assist hospitals serving large volumes of uninsured patients unable to meet the cost of care.

Sadly, a few states appear to have chosen not to offset the harm caused by federal reductions, even though their revenue bases are sound enough to permit them to generate additional funds during crisis periods that see a swelling number of indigent families. For example, Texas, New Mexico, Oklahoma, and Louisiana, which have considerable revenue generating capabilities, have failed to act to supplement existing public health services for women and children losing vital Medicaid coverage, or actually have reduced needed services that might have been partially or totally supported with supplemental state revenues. CDF believes that these states' failure to utilize state revenues to support basic human services is significant in light of the Reagan Administration's long term goal of turning back to the states complete responsibility for funding and administering nearly all human services programs for children.

TESTIMONY PRESENTED
To
SENATE JOINT ECONOMIC COMMITTEE
By
Arthur J. Salisbury, M.D.
Vice President for Medical Services
March of Dimes Birth Defects Foundation
November 17, 1983

I am Dr. Arthur J. Salisbury, the Vice President for Medical Services of the March of Dimes Birth Defects Foundation. As you know, the March of Dimes now devotes its energies and resources to the prevention of birth defects and of other tragic outcomes of pregnancy. I have been asked to comment today on the adequacy of federal funding of maternal and child health services and on the effects of changes in this funding which have been made in recent years.

The Omnibus Budget Reconciliation Act of 1981 created the Maternal and Child Health Block Grant to the states. Seven previously categorical programs were absorbed into the block and the overall level of funding was reduced by approximately 30 percent. Quite predictably, these cuts have forced the states to reduce the extent of services previously provided and to change eligibility criteria reducing the number of mothers and children who can receive the services. No less than 47 states have reported such reductions.

The services which have been cut back or eliminated include prenatal and delivery care, health supervision and preventive services for children, treatment of chronic, disabling conditions of childhood and family planning services. All of these have been repeatedly demonstrated to be among the most cost effective of all health and medical services.

The curtailment of services came at the worst possible time. Unemployment and underemployment with attendant loss of health insurance benefits forced families to seek publicly supported care for which they had previously been able to pay. And they found that clinics had been closed or were unable to take any more patients because of reductions in funding.

Mounting federal deficits present critical prospects now and for the future, but in trying to significantly reduce a 200 billion dollar deficit by cutting appropriations for maternal and child health, which never have exceeded 450 million dollars per year, we have to use an unfortunate analogy, throw the baby out with the bath water.

We know that maternal and child health services are effective in reducing overall and long term costs. I will give just one example. I have drawn on birth data for 1980 studied in California.

Ten thousand women who receive early and regular prenatal care will produce 520 infants who weigh less than 5½ pounds (2500 gms). Not all of the infants will require intensive care, but those who do will have hospital bills of $4.6 million.

Ten thousand women who do not receive prenatal care will produce 1,410 babies who weigh less than 5½ pounds. The costs of intensive care for this group will be $16.8 million. The difference in intensive care cost between the no prenatal care group ($16.8 million) and the group receiving prenatal care ($4.6 million) is $12.2 million. The cost of providing prenatal care to the 10,000 women in the no care group would be $10.0 million ($1,000 each) producing a net savings of $2.2 million for 10,000 women.

The net savings for the approximately 185,000 (5 percent) women now receiving inadequate or no prenatal care would be $40.7 million yearly in intensive care costs alone.

When the Omnibus Budget Reconciliation Act became law in 1981, it was frequently stated, at the White House and on Capitol Hill, that the voluntary and independent sector would be able to fill the gaps created by reductions in governmental funding. The only voluntary agency supporting the provision of prenatal and perinatal care is the March of Dimes. We do this through grants to hospitals, clinics and health departments. These grants are seed monies to be used to improve and expand existing services or to create new ones. The program categories included are physicians and nurses services, patient education and professional education. We are able to budget approximately $7.2 million per year for grants relating to prenatal and perinatal care. If we were to do more, our activities in research on birth defects and in diagnosis, treatment and counseling for genetic or inherited disorders would have to be curtailed. If we were to devote all of our spendable resources to closing the gaps in the availability of prenatal and perinatal care, we could make only a very small dent in the problem. We can fund demonstrations of new medical and educational innovations, such as our new ongoing effort in prevention of preterm delivery. We can provide seed money for new ventures, but we cannot pay yearly clinc, hospital and physician bills for 185,000 grossly underserved pregnant women.

What has been done and what can be done about this and other major problems created by cutting federal expenditures for maternal and child health services?

In recent weeks, the Congress has passed and the President has signed the Labor, Health and Human Services Appropriations Act for fiscal year 1984. This Act includes the amount of $399.0 million for the Maternal and Child Health Block Grant. In 1983, the amount for the Block Grant was $373.0 million, but this was increased by $105.0 million to $478.0 million by supplements contained in the Jobs Bill. We can, therefore, say that the appropriation has been increased by $26.0 million or, since the funds in the Jobs Bill are not available in fiscal year 1984, we can say that the appropriation has been decreased by $89.0 million. I prefer to interpret the 1984 amount as an increase because it is a step in the right direction.

Another step is currently before the Congress. Senator Bumpers, in association with Senators Bentsen, Heinz, Matsunaga, Moynihan and Cranston, has introduced a bill which would increase the level of funding authorized for the Maternal and Child Health Block Grant to $499.5 million for fiscal year 1984. Such an increase would remove the current ceiling on the appropriation level and this would make significant increases in the amounts going to the states for the maintenance and reinstitution of services which have been curtailed or eliminated. We urge passage of Senator Bumpers' bill which is S. 2013.

Another important bill has been introduced in the House by Congressman Waxman. This bill would expand Medicaid coverage for poor pregnant women and their infants who are now excluded. These women include those pregnant for the first time, those in low income families where the primary wage earner is unemployed and, beginning in 1986, women in all low income two parent families. Mr. Waxman's bill would provide 100 percent federal reimbursement to the states for the cost of this expanded coverage. The states would utilize their own income and asset standards for determining eligibility as impoverished.

Senator Cranston has introduced an amendment to the Budget Resolution which would provide similar expansion of coverage under Medicaid for poor pregnant women.

The March of Dimes has endorsed both bills because they would remove, in part, the financial barrier to obtaining prenatal care which now confronts poor women.

I have already discussed the savings in total costs which are possible if women receive prenatal care. Lack of prenatal care probably contributes to approximately 20,000 deaths of newborns each year. Many more survive, but are permanently damaged. We should not allow financial barriers to obtaining prenatal care by the poor be a cause of these losses.

Extending Medicaid coverage to poor pregnant women and increasing the authorization and appropriations for the Maternal and Child Health Block Grant will be significant steps in improving the availability and accessibility of prenatal care.

SENATE FINANCE COMMITTEE:
Oversight Hearing on Maternal and Child Health Block Grant
June 20, 1984

PERSPECTIVES ON THE COMPTROLLER GENERAL'S REPORT TO THE CONGRESS ON THE MATERNAL AND CHILD HEALTH BLOCK GRANT

BY

Paul N. Shaheen, Executive Director
Michigan Council For Maternal and Child Health

The Maternal and Child Health Block Grant Program was introduced to Michigan in the presence of many disruptive factors. Foremost among these was the economic recession which started earlier and was deeper in Michigan than in most other parts of the country.

The State budget began to erode as early as fiscal 1978/79. The slide got underway in earnest in FY 81/82 and combined very unfavorably with the federal reductions which were implemented through the Block Grant Program.

By the end of 1982, Michigan led the nation with an unemployment rate of 17.3% and over three quarters of a million people out of work. We continue with double digit unemployment in our state, now well into its fourth year, and still have close to 500,000 out of work.

The Department of Public Health lost $24.2 million in appropriations from federal, state and local sources during a 16-month period ending in January of 1983, and the Maternal and Child Health Program lost a net $6.7 million in appropriations during the same period. The GAO Report reflected only the expenditure side of the ledger. If one concentrates on that level the agony of the reductions and refocusing of programs is largely missed. As was very accurately pointed out in the Report, state and local officials began even prior to the passage of the Omnibus Reconciliation Bill to reduce program effort and carry forward Title V and other categorical program revenue from 1981 to cushion the shortfall in 1982. Still, several activities were terminated; in our state, because of the combined federal-state reductions, we closed three clinics in Detroit serving 600 women and almost 11,000 children and made across-the-board reductions to other maternity and infant care clinics. Also, as was pointed out in the GAO Report, we were unable to continue the previously federally funded adolescent pregnancy program in our state because of other important priorities.

The economic recession and the unemployment which resulted from it meant that many people in our state became uninsured. Among the most vulnerable were our mothers and children. Michigan noted the largest increase in its infant mortality rate since World War II. This rate continued at higher than average levels through 1982. Only in provisional reports for 1983 has some relief in these high rates appeared.

Thus, services were being leveled out, curtailed and reduced at a time when demand from the unemployed and the medically indigent was increasing exponentially.

Clearly, in 1983 the one-time Jobs Bill assistance was of great help to Michigan. These funds were allocated to all local health departments to address the priority state health problems of high infant mortality. The dollars were targeted toward public health prevention strategies which can increase birth weight, including prenatal care, family planning services, health education and nutrition. To be sure, not all the funds were spent in 1983, and this has helped many of our local public health jurisdictions to provide critically needed services in 1984.

Michigan was not among those states which were able to put large amounts of new state dollars into Maternal and Child Health and Crippled Children's programs. One area of the Report that should be reviewed carefully is the assumption that inflation during this time period for medical care services was 7%. Our experience in the Crippled Children's Program indicates that this number was much higher and that we were able to purchase far fewer services with the same health care dollars than we had in previous years. One has only to look at the prime interest rate during this time period and at inflation in the medical care area to see that this assumption needs review.

Michigan adopted many strategies to cope with the changes brought about by not only the Block Grant but by the economic recession and the corresponding demand for services which it produced. These strategies included forward funding, line item protection for specific programs of interest, development of plans to realign state local service structures and the development of advocacy organizations such as the Michigan Council For Maternal and Child Health.

In the area of forward funding, we found that in states attempting to forward fund services were occasionally thwarted when the funds were removed to meet other state budgetary problems. We found that line item protection needed to built into the state budget process so that visibility and protection was given to program efforts. In this way, we were able to maintain some categorical strength of the program and prevent the loss of both federal and state funds which were needed to service the population for whom Congress appropriated the money.

Michigan has been conducting consolidation of Block Grant type experiments for several years with various local health departments. In our state we have called this "the family health project", and it has been reported on at many public health meetings around the country. Certainly we recognize that the proliferation of federal categorical programs with their conflicting guidelines, reporting demands and funding fluctuations have made administration a nightmare at the local service level. The Maternal and Child Health Block Grant did not solve all these problems, as many of the Maternal and Child Health Programs were not included and perhaps should never be included for various reasons. In this area, it is very difficult to separate block grants as a federal budget cutting strategy from block grants to provide flexibility and administrative ease.

It is our opinion that the effect of the creation of the federal Maternal and Child Health Block Grant strategy was twofold: to cut funds, and to shift responsibility to states and localities so that the federal government could turn its attention to other priorities. It is indeed unfortunate that the 18% cut went through because there were cash-poor states such as Michigan which were unable to be content with the implications of the shift, particularly in light of the needs of the new poor.

Thus, we separate out our state experience in consolidating programs from the federal experience with the MCH Block Grant. We have found that there are many areas where eligibility requirements, reporting demands and funding fluctuations should be linked up so that families and individuals can be served "whole" and at lower cost per unit of service. In fact, our experiences have shown that this can be done,and these reports are available from the Michigan Department of Public Health. When program decisions were moved back toward governors and legislators in the area of maternal and child health, we found that our state needed to concentrate its advocacy efforts where the decisions were made. Thus, one good aspect of the Block Grant program was that it energized many maternal and child health advocates. In our state alone, perhaps nine new groups and coalitions were formed, including ours. These advocates are not likely to become apathetic as the years go by, and certainly our own political and programmatic structure has received an education into the cost containment benefits of preventive maternal and child health services.

Another positive element of the Block Grant Program was that it produced a "can do" attitude on the part of health professionals in Michigan. They began to provide investigations and reports on critical health problems and to take more of a leadership role in addressing these problems, as opposed to simply carrying out federal rules for program of projects and other activities.

I think it is important that some of our concerns regarding the Block Grant Program be addressed. The federal government is not ever going to be able to get out of the business of supporting maternal and child health programs or making and keeping children as a priority for the nation. As Theodore Roosevelt once said, children live in localities and states and vote in local and state elections, but they also vote for President of the United States and are citizens of the country as a whole. As today's children grow into adulthood, they will have to perform increasingly complex tasks in an age of technological change in order to protect our natural environment, maintain our standard of living and keep our national economy competitive with other nations. The government of the United States must consider each of our children as a valuable national resource. Programs such as Maternal and Child Health not only improve the health and enhance the lives of our children immediately, but also expand their potential for significant contributions to the nation as a whole.

Perhaps the question of who will pay the country's Social Security Bill after the year 2000 ought to be rephrased. Obviously, if total reliance is placed on states and localities, we will have a patchwork system of services which in its unevenness will assure that many kids are left behind. We have only to look at our competitor nations such as the Soviet Union and examine their child health policies to realize that a longer term view is needed.

The federal government has certain key responsibilities. Some of these are:

* Setting national goals

* Setting standards for publicly financed health care

* Financing

- Innovation
- Monitoring
- Training

We agree with the President's Commission Report on Biomedical Issues of last year that the federal government has a moral and ethical responsibility for seeing that health care is available to all, especially to mothers and children.

One of the most important roles of the federal government is setting goal standards and financing. The federal government still has the greatest taxing power, and in our state we receive very little return on the tax dollars sent to Washington. If we are to continue to bring our infant mortality rate down to the national goal of nine deaths per 1,000 live births by 1990, we need to expand our efforts to improve birth weight. Key interventions such as family planning, prenatal and infant care and supplemental nutrition all require high federal investments. We believe that these investments will be rewarded through a continuing improvement in our ability to assure that each child will reach his full genetic potential.

Advocacy groups around the country will be able to adjust -and we feel those in Michigan have adjusted- to the political realities expressed through the Block Grant. We work closely with public health officials and other groups concerned with the needs of children, and we feel that the Block Grant has perhaps provided more access to the process. Our greatest concern is to assure that the federal government not absolve itself of all responsibility for promoting the health of the nation's children. Clearly one part of this responsibility will be to make sure that adequate financing is available under the Block Grant Program. Thus, we support Representative Conte and others in their effort to move the Block Grant authorization and appropriation in FY 1985 to $499.5 million.

Thank you for the opportunity to testify here today.

TESTIMONY

TO

SENATE COMMITTEE ON FINANCE

by

The New England Consortium of Childhood Lead Poisoning Programs

June 20, 1984

Testimony

This testimony summarizes the lead poisoning prevention activities in the six state New England area under the Title V Block Grant Consolidation - PL-97-35- for the period 1981-1984.

The New England states recognized both the need and the responsibility to maintain childhood lead poisoning prevention programs despite the defunding of local lead programs under the categorical funding mechanism and the simultaneous decrease in State Title V appropriations precipitated by the 1981 Omnibus Budget Reconciliation Act. This commitment to evaluate and sustain lead poisoning prevention efforts in the face of limited resources and competing child health needs under the state Maternal Child Health Authorities resulted in the following three initiatives:

1. Development of the New England Lead Poisoning Programs, a Special Project of Regional and National Significance, initiated by Rhode Island Department of Health and funded by the Division of Maternal and Child Health, Department of Health and Human Services. This three year project is supporting, through regional training, and technical assistance, specific activities as outlined below, to improve the quantity and quality of lead poisoning control efforts:

   A. A screening assessment project in New Hampshire, where screening did not previously exist. 1800 children were screened in the first 9 months of the project.

   B. Two major regional symposia on lead poisoning.

   C. Four task forces in the areas of data collection, laboratory technology, community and professional education.

D. Development of educational materials to increase public awareness of this health problem.

E. A Regional data collection and reporting system.

F. Individual state contracts for consultation and training.

2. Development of needs assessments in individual states to determine the prevalence of lead poisoning and to define more effective targeting of control efforts. The following examples are cited:

A. Retrospective studies in Connecticut and Maine where state and local program activity affords a 10 year history of lead poisoning data.

B. Pilot screening project in New Hampshire and Vermont to identify the prevalence and high risk areas in the more rural states.

C. A modified N.H.A.N.E.S.II methodology to assess the statewide and local program efforts in Massachusetts. This needs assessment resulted in the funding of three additional local programs through a request for proposal process and expanded capabilities at the state lead program level.

D. Analysis of lead poisoning and census date in Rhode Island has identified an area of the state which required more intensive intervention than had been previously practiced.

3. Development of a statewide planning emphasis in New England, with the following results:

A. Increased screening activities in Rhode Island and Massachusetts where strong state programs previously existed. These states continue to support states who are developing a statewide focus.

B. Increased analysis of statewide activity in more rural states where the true prevalence may be unknown and the seriousness of impact this problem in their population when compared to other child health problems may not be documented.

In summary, the commitment of state Maternal Child Health authorities in New England and the support of N.E.C.C.L.P.P. by the regional and national Maternal Child Health administration have realized several positive outcomes under the Block Grant:

Outcomes

1. Increased coordination with child health programs in each state (WIC, EPSDT, Nutritional services, Handicapped Childrens Services, Head Start, Day care.)
2. Increased coordination on interstate program activities . This network appears strongest in the area of education and training.
3. Improved identification of high-risk areas by maintaining a statewide perspective and shared analytic expertise.
4. Increased emphasis on lead screening as a routine part of child health care.
5. Increased expertise in cost-effective program management. Many of the activities were supported through N.E.C.C.L.P.P. and the Special Supplement to Title V Funds (Emergency Jobs Bill). N.E.C.C.L.P.P. funds will expire September 30, 1985. Without additional resources authorities will continue to face the dilemma of allocating scarce resources among competing child health needs. The New England experience suggests that creative approaches to maintain and lead poisoning prevention services can be developed and shared among states where leadership, commitment and expertise are strong and fiscal resources are adequate.

Statement of David Axelrod, M.D.
Commissioner of Health
State of New York

Testimony Presented to the
Subcommittee on Health of the
Committee on Finance
United States Senate

On the Maternal and Child Health
Services Block Grant

June 20, 1984

Thank you for the opportunity to describe New York State's experience in administering the Maternal and Child Health Services Block Grant (MCHSBG). Although we were initially skeptical about the use of block grants for health programs, we have, through our experience, come to agree with their utility. During the last three years, we believe that we have refined the use of the funding provided by the block grant in order to achieve the maximum results with the dollars spent.

This does not mean that the 18 percent cutback in funding for this program in Fiscal Year (FY) 82 went unnoticed. Programs were eliminated and most remaining programs received reduced funding. Since then, many service providers have received a constant funding level, as no additional funds were available to absorb the costs of inflation. In addition, although the flexibility given the States in their allocation of block grant dollars is critical, it would be absurd to think that flexibility helped ameliorate the effects of the 18 percent reduction in funds.

We believe that New York State is using the block grant dollars in a most effective manner. Our programs are truly focused on preventive health care, which we believe is the most productive use of these dollars. However, despite the targeting of our programs to the areas of greatest need, the health care problems of the low-income, high-risk populations served by MCHSBG programs continue to be severe. Much more remains to be done, and additional support from the Federal Government is crucial in meeting those needs.

o Despite the steady improvement of the infant mortality rate in the United States, we are still considerably behind other industrial nations in this area. From year to year, we rank from 15th to 18th, usually following countries such as Japan, Canada, Australia, Hong Kong and France. Infant mortality is recognized as the most sensitive indicator of health status in a country.

o Although we have continued to improve the infant mortality rate, great disparities exist according to race and ethnic origin. A black child has almost two times the risk of dying before reaching his or her first birthday than does a white child.

- Between 1981 and 1982, death rates for all infants increased in 11 states; for white infants in 9 states and for non-white infants in 13 states.

- Low birth weight babies account for from 6.8 to 7.4 percent of the total newborn population in most states. These low birth weight babies, however, are responsible for 65 percent of deaths between birth and two months and 60 percent of all infant deaths.

- Lack of adequate medical and other health care during pregnancy has been demonstrated to be an important factor in low birth weight and the health status of the newborn infant. Over the past three years, there has been a decrease in the percentage of women receiving prenatal care during the first three months of pregnancy and a rise in the percentage of women receiving late or no prenatal care.

- Federal budget cuts and modifications in Title V Maternal and Child Health Programs and Medicaid have contributed significantly to increasing numbers of poor women and children without health insurance or money. This in turn has led to greater numbers of people being turned away from prenatal, delivery and other needed care.

In addition to the above description of the problem, the following data on childhood morbidity further illustrates our concerns:

- In New York State there were more children living in poverty in 1980 than in 1970, with nearly one in every five children below the poverty level.

- Approximately 25 percent of all visits to pediatricians involve upper and lower respiratory infections. The low income family is more likely than any other to receive late or no treatment for such conditions. If not treated, many of these conditions can result in avoidable hospitalization and in permanent damage.

- While immunizations of school-aged children has proceeded well after the establishment of State legislation mandating immunizations, many pre-school children, especially in low-income areas, are still inadequately protected.

- In the nine urban counties of New York State, 120,000 to 140,000 children less than six years of age are screened annually for lead toxicity. In 1981, 4.3 percent were found to have high lead levels.

The receipt of $7.74 million in MCH funds from the Jobs Bill ("Federal Expenditures to meet National Needs Act of 1983") in FY 83 provided New York State with an opportunity to begin restructuring our maternal and child health program in order that maximum impact could be achieved with the service dollars spent.

Much effort was expended in determining innovative uses for MCHSBG funds and targeting the funds to those areas and persons most in need. This critical process caused a delay in the expenditure of these funds until FY 84.

After careful review, including discussions with the New York State Maternal and Child Health Services Block Grant Advisory Council, we identified high priority programs in New York State which could reduce morbidity and mortality in the maternal and child health population. Qualified public and non-profit agencies were asked for proposals to carry out these programs including: prevention of low birth weight, the Infant Health Assessment Program to identify and provide follow-up and referral services to infants born at high risk for physical and developmental handicaps, primary and preventive health care for children birth to five years, a new statewide lead poisoning screening and referral program, new and innovative school health services projects, programs designed to prevent unplanned pregnancies in adolescents, preventive dental services for high risk and underserved children, and programs to coordinate the services needed by chronically ill children.

Prevention of Low Birth Weight Program

MCHSBG monies are being used to address the problem of excessive incidence of low birth weight among newborns of mothers who reside in areas of the State where the infant mortality rate and rate of infants born at low birth rate significantly exceed the State averages. We believe that an intensive effort in such areas to promote enrollment of pregnant women in a comprehensive and continuous program of prenatal care will result in a significant reduction in low birth weight and its adverse sequelae among newborns.

Low birth weight is the single most important contributor to infant health and disability; each year more than three-quarters of all neonatal deaths in New York State occur among infants weighing less than 2500 grams at birth -- infants who comprise less than one-tenth of all live births. Medical research indicates a clear and powerful relationship between low birth weight and the excessive incidence of mental retardation, cerebral palsy and other neurological abnormalities as well as numerous, more subtle, behavior, learning and language disorders.

In designing the program criteria, we adhered to the belief that a reasonable approach to low birth weight prevention must recognize and address the biological, social, and environmental precursors of low birth weight through the provision of social support and education services in addition to a high quality program of medical care. The major elements of the funded programs include:

o Outreach services to assure that the highest risk clientele is reached by the project. This includes enrollment from local social services agencies, WIC agencies, other public and voluntary agencies, high schools, and specific alcohol, drug abuse and mental health agencies;

Establishment of additional prenatal visits, if indicated, for the highest risk group, with development of individual case management plans;

- Patient education;
- 24-hour availability of project staff;
- Formal linkages with WIC providers;
- Social services assistance and counseling; and,
- Evaluation protocol.

Linkage Program for Adolescent Mothers in Areas of High Need and With Large Teenage Populations

MCHSBG funds are being used to support programs that assist pregnant adolescents in carrying to term so as to improve pregnancy outcomes for pregnant adolescents, and improve their life situation.

One of the State's programs to reduce the incidence of low birth weight in infants addresses the care of pregnant adolescents through the family planning network in New York. Family planning agencies utilize a network model in areas where high risk for teenage pregnancies and consequent low birth weight infants is present. A case management approach is used, providing health and related services to the target population in a coordinated, comprehensive manner. Services provided include pregnancy testing and counseling; family planning services; primary and preventive health care; nutrition information; counseling and services; referral screening and treatment for sexually transmissable diseases; referral for initial pediatric care; education services in sexuality and family life; referral to appropriate educational and vocational services; and counseling for extended family members. Optional services include transportation, legal services, referral to other health services, consumer education and homemaking.

Infant Health Assessment Program

MCHSBG funds are providing support to local health departments and public health nursing services in order to identify, refer to care and follow-up infants and young children who may be at high risk for physical and developmental handicaps.

To direct the State's preventive health services toward populations in greatest need, and to make certain that essential treatment services are available to, and utilized by, the families of high risk infants, New York is establishing an information system that links knowledge to action. The Infant Health Assessment Program (IHAP) will integrate data from the vital records system and other registries with information from other service providers.

The IHAP will serve an archival role, identifying infants and young children at risk for physical and developmental disabilities and alerting public and private health care, social service, and education providers of the number and location of such children. Local health agencies will follow these infants and children to ensure that necessary services are received in a timely and coordinated fashion. The IHAP will move all preventive efforts forward to the earliest time possible after birth and ensure coordination, not duplication, of services.

Primary and Preventive Health Care for Children Birth to Five Years

MCHSBG funds are supporting projects that coordinate programs of screening, direct medical services, primary prevention (such as immunization and health education) and nutrition services to children ages 0-5 at high risk of experiencing preventable morbidity, excessive hospitalization, and mortality.

The central message of the report of the Select Panel for the Promotion of Child Health, Better Health for Our Children: A National Strategy is this: "Early infancy and young childhood are critical life stages during which vulnerabilities are great and the possiblities for helpful health care interventions numerous. If a child is helped to mature through this period safely, with preventable health problems avoided, with others identified and managed as early as possible, with effective measures such as immunizations taken to avoid later health problems, and with the nurturing capacites of his or her parents developed and supported, the young person's chances for a healthy childhood and adulthood are increased dramatically."

The Select Panel found that "in general, children in low-income families are less likely to have a regular source of medical care, less likely to have received any medical care during the year, and much more likely to have been hospitalized, and if hospitalized, to have remained in the hospital longer. This finding, unfortunately, is applicable today in New York State. Well child and heath promotion services for the Medicaid-eligible population and the poor (household incomes at or below 185 percent of poverty) are not widely available in either the upstate or downstate regions. Care for most Medicaid-eligible children in New York State is limited to curative services rendered on an episodic basis.

We believe that through a comprehensive program of outreach and preventive and primary health care, in coordination with the State's Child Health Assurance Program, WIC, Medicaid and other existing service programs, the health status of children ages 0-5 years in low income families can be signficantly improved.

This program builds upon the base of health care providers already providing some primary and/or preventive care services, targeted to the low income 0-5 year age group. The goal is to assure that comprehensive care is available to this population and that a basis is established for continuity of care beyond that age.

Specific program objectives are:

- Decreasing the preventable causes of childhood morbidity and mortality in the high risk population;
- Increasing the use of primary prevention measures in early child health care;
- Coordinating health, nutrition and social services by establishing or strengthening linkages with existing programs; and,
- Increasing the use of primary prevention measures in early child health care through a parent-centered program, including instruction and/or counseling.

Lead Poisoning Control Program

MCHSBG funds are being used to support new childhood lead poisoning control program services. The program is targeted to jurisdictions where the percentage of black children and/or children ages one through five years living in households at or below 185 percent of the poverty index is high. Local health departments are providing these services.

A national estimate of blood lead levels in children reported that four percent of all children ages six months through five years have blood lead levels equal to 30 micrograms or more per deciliter of whole blood. In poor families (annual income of less than $6,000) this degree of elevated blood lead is present in almost 11 percent of the children (5.9 percent white, 18.5 percent black). Data show that black children, regardless of family income, are at highest risk for lead poisoning. Therefore, this program emphasizes services to these children. We believe that a coordinated program of outreach, screening, medical follow-up, education and environmental intervention during the early years of growth and development can greatly assist in the prevention of acute and long range physiological, neurological and psychological defects and their concurrent costs.

School Health Projects

The goals of this program are to promote good physical and mental health, prevent illness leading to disability and hospitalization and to facilitate learning and healthy lives by permitting licensed health care facilities to provide services in schools. The services provided emphasize prevention, health promotion, identification and management of health problems, and some treatment services. They assure adequate access and availability of comprehensive primary care services to high school children in areas of high need.

Schools provide an excellent opportunity to reach children and adolescents. Many licensed health care facilities have extensive experience in providing primary and preventive care services.

This program brings together and builds upon the strengths of schools and health facilities.

In addition to supporting the development of additional school health projects, MCHSBG monies are supporting expansion of similar school health projects supported by New York State funds. Participating health care providers have expanded their services to include pre-schools, day care centers, Head Start Programs, elementary and junior high schools.

Family Planning Services to Prevent Unplanned Pregnancies in Adolescents

MCHSBG funds are supporting comprehensive family planning services to sexually active adolescents in discrete family planning settings. In recent years, New York State has placed special emphasis on the subject of adolescent reproductive health, and a significant portion of funds has been expended for services to prevent unplanned pregnancies in adolescents. Considering that the incidence of sexual activity in adolescents rose by two-thirds between 1971 and 1979, and considering the rather moderate rise in teen pregnancy rates during the same time period, it is apparent that all family planning efforts combined have had a marked impact, particularly in rural counties.

The comprehensive services provided by these projects include:

- Outreach and education;
- Special teen counseling and education sessions on site;
- Comprehensive medical history and physical exam;
- Provision of contraception; and,
- Follow-up for specific teen issues and medical problems.

Dental Services for High-Risk And Underserved Children

MCHSBG funds are supporting programs that provide dental screening, referral, and preventive programs for children (ages 0 to 18 years) who are at high risk for dental disease and who are underserved with respect to utilization of professional dental care services. We believe that targeting dental screening, referral, and low cost preventive programs to areas whose populations exhibit a high degree of poverty and suffer a disproportionate share of health problems can significantly lower the incidence of dental disease among children in these areas.

One of the most cost-effective means of reducing dental disease is to employ community-based mid-level practitioners, i.e., dental hygienists, to provide screening to groups of targeted high risk children, such as those of low socioeconomic status in schools, in day care centers, and at Head Start sites, WIC sites, and other locations.

Not only will these projects provide preventive dental services to high risk children; they will also provide a point of entry into the dental health care system for these underserved children, an opportunity for early intervention in the disease process and an effective referral system to ensure that needed dental care is obtained.

Coordination of Care for Chronically Ill Children

Projects have also begun which coordinate care for chronically ill children. The providers' major emphasis is on integrating various health and related support services for chronically ill children, fostering an easy interchange of information and facilitating smooth referrals of patients.

It is estimated that 10 to 15 percent of the childhood population in the United States has a chronic condition, while 1 to 2 percent have a severe chronic illness. In 1977, chronic conditions accounted for 36 percent of total hospital days for all children less than age 15 in the United States.

Most efforts to meet the needs of chronically ill children are directed at managing discrete disease entities, rather than at ameliorating the multiple physical, social, psychological and family problems which can arise from any chronic illness or condition. In addition, most services for the chronicaly ill are rendered in hospitals and are confined to the period in which the child is in need of inpatient care. Little effective discharge planning takes place for the time when the child returns to the community, and in most jurisdictions, few home care and family support services are available to prevent hospital readmission or eventual commitment to long-term care institutions. Overall, the most serious shortcoming of most current efforts to care for the chronically ill child is the characteristic absence of a coordinated regimen of care which addresses the needs of the "whole child" and those of the immediate family.

The ultimate goals of the new programs are to improve the quality of life for those children and to reduce their need for further hospitalization. These programs provide the following: coordination and integration of services, an interdisciplinary team approach, formulation of individual services plans, education for families, and family and child counseling.

Although our maternal and child health services are focused on the areas of greatest need, much remains to be done and additional federal funds are critical to support these needed efforts. The block grant has provided the State with an opportunity to restructure maternal and child health care programs to best meet unmet need. But we have done so with an inadequate funding level. We continue to inadequately fund the most crucial maternal and child health preventive care programs and continue to fund costly sick care. We do not provide adequate support for prenatal care, but pay great amounts for newborn intensive care services. It is clear that a greater investment in preventive programs designed especially to reduce the incidence of low birth weight will help to reduce infant mortality and morbidity rates. Continuation of the current federal emphasis on funding acute medical care makes little sense. It is absolutely crucial that the dollars be invested on the front end

- for preventive services - to both ensure healthier, more productive citizens and to reduce the level of funds needed for sick care.

An increased funding level of at least $478 million is critical. That level will permit New York to continue our current program initiatives including the innovative projects supported by the Jobs Bill. If the FY 85 funding level is less than $478 million, a reduction in the current program will be necessitated, and much of our effort to develop and implement new programs will have been in vain. The State will be unable to continue the essential services now being provided to mothers and children at risk. Among the programs which will have to be eliminated or severely reduced are those designed to prevent low birth weight, to provide primary and preventive health care for children birth to five years, lead poisoning screening and referral services, school health services projects.

Although we have developed innovative programs targeted to those with greatest need, there is a limit to how much we can accomplish through better targeting and increased effectiveness and efficiency. Our public health problems will not go away; it is crucial that our maternal and child health care program efforts be adequately funded.

New York State is using the block grant dollars effectively with funds targeted to proven, cost effective, preventive health measures. We believe that given the limited dollars available from this source of money, these type of programs will have the greatest results. It is also clear that nationwide, this money is not always being used for preventive services. We believe that Congress should clarify that the block grant funds be spent for preventive health care. But it is equally critical that states continue to be given the amount of flexibility now available in determining which preventive health programs are most needed in each State.

Thank you for providing us with the opportunity to share our views. We hope that as funding and program decisions are made for these critical programs, you consider the potentially negative results of inadequate federal support.

SPECIFIC COMMENTS ON THE GAO REPORT ON BLOCK GRANTS

For the record, we would like to bring to your attention certain errors contained in the GAO report on block grants regarding New York State's expenditures.

I. Lead-Based Paint Poisoning Prevention Programs

The GAO has reported the following expenditure levels for this program in Appendix VIII (in thousands):

	1981	1982	1983	Change	
				$	%
New York		$3,868	$2,055	($181)	(47)

The correct numbers are:

	1981	1982	1983	Change	
				$	%
New York	$1,688	$1,382	$1,217	($165)	(12)

In addition, the report notes with respect to the Lead-Based Paint Poisoning Program that "New York's funding change may be overstated, although the declining trend is real. Part of this decline resulted from a change in the way the program was accounted for in 1983." This statement is incorrect and should be deleted. In addition, the 1982-83 figures given by GAO appear to have included extensive matching moneys for localities, and do not reflect Federal MCH funding."

II. Sudden Infant Death Syndrome (SIDS) Programs

The GAO has reported the following expenditure levels for this program in Appendix IX (in thousands):

	1981	1982	1983	Change	
				$	%
New York		$300	$90	($210)	(70)

The correct numbers are:

	1981	1982	1983	Change	
				$	%
New York	$287	$287	$277	($10)	(3)

In addition, the report notes with respect to the SIDS programs that "New York's funding change may be overstated, although the declining trend is real. Part of this decline resulted from a change in the way the program was accounted for in 1983." This statement is incorrect and should be deleted.

III. In the section of the report on Sudden Infant Death Syndrome Services - Program Reductions Reflect Changing Priorities, the following incorrect statement regarding New York State should be deleted:

> "New York eliminated funding for SIDS family counseling and research projects because of higher priorities and because services could be provided as part of its general MCH program."

The program received a minor reduction in funding from 1982 to 1983 and, in fact, the funding level for 1984 includes an increase.

IV. Adolescent Pregnancy Prevention Services

The GAO has reported the following expenditure levels for this program in Appendix X (in thousands):

	1981	1982	1983	Change	
				$	%
New York		$1,175	$1,092	($83)	(7)

The correct numbers are:

	1981	1982	1983	Change	
				$	%
New York	$1,296	$1,053	$975	($78)	(7)

V. Genetic Disease Testing and Counseling Services

The report contains no expenditure information for New York State for this program and notes the following:

"New York is excluded because comparable data was not available. Total expenditures for 1983 were $965,000; although state officials indicated no significant changes between 1982 and 1983, 1982 expenditures could not be provided."

The correct numbers are:

	1981	1982	1983	Change	
				$	%
New York	$1,628*	$1,535*	$1,006	($721)	(253)

* $1.25 million of the funding for the genetics program was provided through a categorical grant in FY 81 and FY 82.

It should be noted that the FY 84 funding level for this program is $1.6 million.

VI. Comprehensive Hemophilia Diagnosis and Treatment Centers

The GAO has reported the following expenditure levels for this program in Appendix XII (in thousands):

	1981	1982	1983	Change $	 %
New York		$480	$381	($99)	(21)

The correct numbers are:

	1981	1982	1983	Change $	 %
New York	$479	$355	$324	($31)	(9)

Awards were made directly by the Federal Government to providers.

VII. It should also be noted that the New York State section of Appendices III and XIV may require adjustments to reflect the above corrections.